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Partnership to Align Social Care
A National Learning & Action Network

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Working With Community Care Hubs to Address Social Drivers of Health

A Playbook for State Medicaid Agencies

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About Partnership to Align Social Care

The Partnership to Align Social Care, A National Learning & Action Network (Partnership) is a national collaborative with the goal of co-designing a sustainable health and social care ecosystem. The Partnership is supported by leaders from the health care sector, community-based organizations, government and philanthropy. Our stakeholders are working together to co-design a strategy to facilitate operating arrangements between health care organizations and networks of CBOs to deliver social care services. More info about the Partnership is available on our website, www.partnership2asc.org.

About The SCAN Foundation

This Playbook is supported, in part, by a grant from The SCAN Foundation—advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit http://www.TheSCANFoundation.org.

Working With Community Care Hubs to Address Social Drivers of Health

A Playbook for State Medicaid Agencies

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Executive Summary

Health and well-being require far more than medical care. Research shows that personal behaviors, physical environments and socioeconomic factors—commonly referred to as the social drivers of health (SDOH)—are responsible for 80 percent of health outcomes. Individuals enrolled in Medicaid experience disproportionate rates of complex health and social needs.[1] With this in mind, state Medicaid agencies are increasingly looking beyond the health care system for solutions to improve health outcomes and achieve value.[2]

Community-based organizations (CBOs) are emerging as critical partners in state efforts to address SDOH.[3,4] Trusted by the communities they serve, CBOs have deep relationships, knowledge of the local environment and critical expertise on the delivery of social care. Despite their promise, challenges around the establishment and sustainability of relationships between CBOs and health care organizations persist, reflecting the different histories, institutions, cultures, business practices and funding streams of today's siloed health and human services infrastructures.[5]

Community Care Hubs (CCHs) are community-centered entities that organize and support networks of CBOs through a centralized administrative and operational infrastructure to help to overcome these challenges—to more meaningfully and efficiently integrate CBOs and the health-related services they offer into the health care continuum. CCHs can ease the implementation burden that would otherwise come with ad hoc partnerships between CBOs and health care organizations, offering core functions including developing and maintaining a network of CBOs; advancing a collective vision for CBO-health care partnerships; centralizing administrative and operational infrastructure; and managing financial resources.

This Playbook is intended to be a resource for state Medicaid agencies seeking to partner with CCHs in the design and implementation of SDOH initiatives. The Playbook offers an introduction to the key functions of CCHs, and practical advice on how state Medicaid agencies can collaborate with CCHs to:

1. **Engage Communities**: State Medicaid agencies and CCHs can work together to build buy-in and trust with CBOs and community members and gather feedback from a diversity of voices to inform state SDOH efforts.
2. **Expand Community Capacity**: State Medicaid agencies can collaborate with CCHs to expand the capacity of both CCHs and their affiliated CBOs to ensure their readiness to deliver social services on scale and in alignment with the service goals of state SDOH initiatives.
3. **Support Operational Excellence**: State Medicaid agencies can leverage CCHs to help establish the infrastructure and business practices required to bridge the gap between health and human services organizations, promoting efficiency and accountability between partnering organizations.
4. **Create Pathways to Financial Sustainability**: State Medicaid agencies can work together with CCHs to help promote the sustainability of partnerships between social service and health care organizations. CCHs can provide valuable input to ensure appropriate and equitable payment rates for CBOs; help leverage funding, expertise and infrastructure from other federal, state, local and private organizations; and support evaluations that demonstrate the value of the partnerships.

5. **Look Upstream**: State Medicaid programs seeking to address SDOH and health equity have an opportunity to contribute to larger collective efforts to invest in the communities in which they operate. With their diverse network of CBOs and partners in the community, CCHs can help state Medicaid agencies and other federal, state and community partners come together on community revitalization and reinvestment efforts, on strategies to promote a robust and diverse workforce, and to help mobilize a variety of financial resources and advocacy efforts to improve the broader ecosystem in which these SDOH initiatives operate.

This Playbook includes practical examples, tips and links to materials used to support SDOH and CCH efforts in communities across the country. Appendices provide additional details and examples from state and national initiatives.

State Medicaid agencies, working alongside community partners and health care organizations, have an opportunity to effect long-lasting change for the individuals and communities they serve. By offering practical guidance and resources on integrating CCHs and their contracted CBOs into the health care continuum, this Playbook seeks to unlock the full potential of community partnerships and support states in their efforts to ensure individuals enrolled in Medicaid live longer, healthier and happier lives.

Setting the Context: An Introduction to Community Care Hubs

Background on Community Care Hubs

Health and well-being require far more than medical care. Research shows that personal behaviors, physical environments and socioeconomic factors, such as access to housing, food, transportation, education and personal safety—commonly referred to as the social drivers of health (SDOH)—are responsible for 80 percent of health outcomes.[6] The disproportionate impact of COVID-19 upon communities of color has further exposed the impact of racism, poverty and other structural and systemic inequities on health,[7] amplifying the call to rethink how the health, public health and social services sectors can work together to improve health and advance health equity.

Medicaid[8] plays a pivotal role in the collective effort needed to address drivers of health. As the largest health care payer for individuals with low incomes and disproportionate rates of complex health and social needs, state Medicaid agencies are increasingly looking beyond the health care system for solutions to improve health outcomes and achieve value.[9] Today, nearly every state in the nation has implemented at least one policy—from SDOH screening requirements to the use of closed loop referral systems, to payment for interventions to address health-related social needs—aimed at addressing SDOH and advancing health equity.[10]

Definition: A Community Care Hub (CCH) is a community-centered entity that **organizes and supports** a network of community-based organizations providing services to address health-related social needs. It **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 health care organizations** and fosters **cross-sector collaborations** that practice **community governance** with authentic **local voices**.

Source: Partnership to Align Social Care

Community-based organizations (CBOs) are emerging as critical partners in state efforts to integrate social care into the health care continuum.[11,12] CBOs include public and private non-profit organizations that represent a community or significant segments of a community and provide educational, health, social support or other related services to individuals in the community.[13] They include organizations providing, for example, nutrition, housing and transportation services; coordination of long-term services and supports; and/or support for those experiencing interpersonal violence. Many offer culturally and linguistically tailored services for Black and Indigenous people of color (BIPOC) and/or immigrant/migrant communities. Trusted by the communities they serve, CBOs have deep relationships, knowledge of the local environment and critical expertise in the delivery of social care. In efforts to address SDOH, CBOs can, for example, provide needed social services, link individuals and their families and caregivers to other sources of social care, work with

individuals to strengthen their engagement with their health care providers, and free up the bandwidth of health care providers to focus on clinical interventions, all of which can contribute to better health outcomes and lower costs.[14]

Despite the promise of CBO partnerships, challenges around the establishment and sustainability of relationships between CBOs and health care organizations persist, reflecting the different histories, institutions, cultures, business practices, information systems, service areas and funding streams of today's siloed health and human services infrastructures.[15] Community Care Hubs (CCHs)—community-centered entities that organize and support networks of CBOs—can help to overcome these challenges, to more meaningfully and efficiently integrate CBOs into the health care continuum. Promoting collaboration among CBOs in a community rather than competition for already-scarce resources, CCHs are grounded in the theory of collective impact, which posits that "a highly structured collaborative effort can achieve substantial impact on a large-scale social problem that a single organization or intervention cannot achieve alone."[16,17,18]

Note: For purposes of this Playbook, **health care organizations** include but are not limited to: managed care organizations, accountable care organizations (ACOs), hospitals, health systems and other types of provider organizations.

CCHs can ease the implementation burden that would otherwise come with ad hoc partnerships between CBOs and health care organizations. CCHs relieve health care organizations of finding, contracting with and managing multiple independent CBOs, who are both sufficiently grounded in their local communities and collectively span the often large geographic regions under the health care organization's charge. CBOs are able to partner with multiple health care organizations with more consistent policies and systems through just one contract with the CCH.

Finally, CCHs can help expand the reach and capacity of Medicaid funding to address the root causes of health disparities. Persons who are adversely impacted by SDOH rarely present with only one issue. By cultivating an integrated social care delivery system of diverse CBOs, CCHs ensure a seamless mesh of stakeholders working together to create a holistic social care delivery system to address SDOH and the root causes of health disparities.

The CCH model has deep roots in efforts to serve populations who are aging and/or disabled, and has been supported by the U.S. Department of Health and Human Services, Administration for Community Living (ACL).[19] Although still in the development phase, CCHs are evolving to serve a wider and more diverse array of populations,[20] and increasingly are being recognized as valuable partners to health care organizations and state Medicaid agencies.

National Examples of Community Care Hubs

- **Area Agencies on Aging (AAA) and Centers for Independent Living (CIL)** receive funding from the U.S. Department of Health and Human Services, Administration for Community Living (ACL) authorized under the Older Americans Act and the Rehabilitation Act. AAAs and CILs provide information, referral assistance and social care navigation services and manage a local network of CBOs that deliver comprehensive community-based services to older adults and persons with disability. Over time, AAAs and CILs have evolved to form CCHs. CCHs have developed increased capacity to manage multiple health care contracts as well as strengthened operational and administrative infrastructure to support management of health information, delivery of services, braiding of funding to finance services, billing and quality reporting. These hubs vary in structure, funding sources, geographic reach and services based on community need.
- In the **Pathways Community HUB model**, a network of local care coordination agencies are organized to identify social health risk factors at the individual and community levels and connect individuals to social service resources to address their needs. Under the model, the HUB is a neutral, accountable and transparent entity that hosts the network of care coordination agencies and provides the operating infrastructure. The "Pathways" are the specific tools and checklists the HUB and care coordinators use to track an individual's identified risk factors and services through to a measurable outcome that is tied to a specific payment. As of October 2022, several counties in states across the country, including, Ohio, Pennsylvania, Washington, Michigan, Wisconsin, Texas, and New Mexico use the Pathways Community HUB model.

Working with Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies **(the Playbook) is intended to be a resource for state Medicaid agencies seeking to partner with Community Care Hubs in the design and implementation of SDOH initiatives**. Ultimately, state Medicaid agencies, working alongside community partners and health care organizations, have an opportunity to effect long-lasting change for the individuals and communities they serve. By offering practical guidance and resources on integrating CCHs and their contracted CBOs into the health care continuum, this Playbook seeks to unlock the full potential of community partnerships and support Medicaid agencies in their efforts to ensure individuals live longer, healthier and happier lives.

Examples of State Medicaid Agencies Working With CCHs

- New York's pending 1115 waiver amendment proposes to invest in Social Determinant of Health Networks (SDHNs)—coordinated networks of CBOs that provide interventions to address a range of social care needs. Each SDHN will have a lead entity that contracts with health care providers on behalf of its CBO network and supports CBOs in various ways, including referral coordination, capacity-building investment and with data and reporting requirements.
- 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.
- Indiana's Managed Long-Term Service and Supports RFP requires its managed care entities (MCEs) to contract with its current aged and disabled waiver care management entities (i.e., AAAs) and other independent care management providers for at least 50% of the plans' HCBS service coordination during the first two years of the program, after which they can either continue to contract services or submit a transition plan to the state.

Community Care Hubs: Core Functions

While CCHs vary in their geographic reach, populations served and types of health-related services provided, they typically share certain core functions that help them build bridges between health care organizations and CBOs.[21]

- **Developing and Maintaining a Network of CBOs**: CCHs' primary responsibility is to form and maintain an effective and efficient network of CBOs prepared to partner with health care organizations to meet the needs of the community. This typically requires recruiting CBOs that reflect the community and span the geographic region being served; assessing CBO capacity and readiness; and contracting with and onboarding CBOs. CCHs may also be able to support the development and maintenance of directories of social services in a community, identify gaps in needed service capacity and contribute to and align community health and other needs assessments that map out community health-related needs and resources.
- **Advancing a Collective Vision for CBO-Health Care Partnerships, SDOH Initiatives and Health Equity**: CCHs also can promote synergies among CBOs and health care entities by helping to establish a shared vision and values among participants, and ensuring that a diverse and representative range of community members, including those with lived experience, are included in the planning, design and governance of new programs and systems.

- **Centralizing Administrative and Operational Infrastructure**: CCHs can leverage economies of scale to create shared infrastructure that lowers the cost of entry for small and diverse CBOs to participate in meaningful contracting with health care organizations, and at the same time maximize efficiencies across all partners. Specifically, CCHs can help establish centralized infrastructure to support billing and payment operations, referral management, outreach and marketing, service delivery fidelity, training and technical assistance support, and compliance with contractual, regulatory and business requirements. CCHs can also facilitate cross-sector data exchange, including helping to define standards related to privacy and information security, data collection and reporting, and deployment of interoperable health information technology. Finally, CCHs may be able to support evaluation efforts, which are essential to demonstrating the value of health-related interventions.
- **Managing Financial Resources**: CCHs can help negotiate agreements that ensure CBOs are paid sufficiently and equitably for their services to support operational sustainability. CCHs also may be able to blend and braid funds from multiple sources, inclusive of but not limited to Medicaid, to support ongoing operations. Finally, CCHs are well-positioned to guide planning and deployment of up-front investments in the infrastructure necessary to launch and maintain CBO-health care partnerships, including documenting resource and workforce needs to meet service demand.

Getting to Work: How State Medicaid Agencies and CCHs Can Collaborate to Address SDOH

While many state Medicaid agencies encourage or require their managed care plans or health care providers to develop partnerships with CBOs, strategies are still emerging for how best to support these partnerships. CCHs offer a promising approach for communities, health care organizations and states to work together to build a strong infrastructure, promote operational excellence and continue to build long-lasting trusted relationships with the communities they serve.

This Playbook focuses on how state Medicaid agencies can best collaborate with CCHs to support efficient, effective and sustainable relationships between health care organizations and CBOs in the design and implementation of initiatives to advance state health and health equity goals. To this end, the following chapters outline how state Medicaid agencies can work with CCHs to:

1. **Engage Communities**: State Medicaid agencies and CCHs can work together to build buy-in and trust with CBOs and community members and gather feedback from a diversity of voices to inform state SDOH efforts.
2. **Expand Community Capacity**: State Medicaid agencies can collaborate with CCHs to expand the capacity of both CCHs and their affiliated CBOs, through both financial and technical assistance, to ensure their readiness to deliver social services on scale and in alignment with the service goals of state SDOH initiatives, and to foster productive, equitable relationships with health care partners.
3. **Support Operational Excellence**: State Medicaid agencies can leverage CCHs to help establish the infrastructure and business practices required to bridge the gap between health and human services organizations, promoting efficiency and accountability between partnering organizations.
4. **Create Pathways to Financial Sustainability**: State Medicaid agencies can work together with CCHs to help promote the sustainability of partnerships between social service and health care organizations. CCHs can provide valuable input to ensure appropriate and equitable payment rates for CBOs; help leverage funding, expertise and infrastructure from other federal, state, local and private organizations; and support evaluations that demonstrate the value of the partnerships.
5. **Look Upstream**: State Medicaid programs seeking to address SDOH and health equity have an opportunity to contribute to larger collective efforts to invest in the communities in which they operate. With their diverse network of CBOs and partners in the community, CCHs can help state Medicaid agencies and other federal, state and community partners come together on community revitalization and reinvestment efforts, on strategies to promote a robust and diverse workforce, and to help mobilize a variety of financial resources and advocacy efforts to improve the broader ecosystem in which these SDOH initiatives operate.

State Medicaid agencies interested in investing in CCHs for the first time may not know where to begin. A foundational step is working alongside the communities to develop a comprehensive understanding of the current landscape of existing CBOs and CCHs, including the resources they offer their communities, their readiness to partner with health care organizations, and the challenges they face. Working with CCHs—or helping to form new CCHs—will require a state Medicaid agency's investment of time and resources. However, when well executed, the up-front investment in the model can bring in a more diverse array of CBOs and help Medicaid agencies more effectively and sustainably deliver whole person care.

Moving forward with a CCH also requires financial investment. While not the focus of this report, state Medicaid agencies may leverage various authorities to finance the CBOs' costs of delivering health-related services, the up-front costs for CCHs and CBOs to enter into new agreements and expand their service capacity, and at least a portion of the costs for the IT infrastructure that CCHs, CBOs and health care organizations need to exchange data efficiently. Examples throughout the Playbook highlight how state Medicaid agencies have supported these costs; Medicaid financing authorities also are outlined in Appendix A for states' consideration.

The remainder of the Playbook will focus on how state Medicaid agencies can best collaborate with CCHs to advance their state health and health equity goals, including call-out boxes and appendices with resources such as sample contract language, guidance, and templates from Medicaid agencies, CCHs and health care organizations. The Playbook concludes with three appendices, including:

- Appendix A: Medicaid Authorities to Support Financing of CCHs
- Appendix B: Examples of CCHs
- Appendix C: State Strategies That Expand the Role of CBOs in the Health Care Continuum

1: Engage Communities

A guiding principle for any state Medicaid SDOH initiative is to engage with potential community-based and health care partners early and often. CBOs and health care entities have historically operated in silos, with different cultures, missions, funding sources, financing mechanisms and regulatory policies. Scalable efforts to address health-related social needs and integrate social care into the physical and behavioral health continuum require an intentional bridging of these two worlds. Because health care entities are often equipped with more financial, social and political capital, there exists the risk that social services will be "overmedicalized" through this type of integration, potentially undermining the value they bring to SDOH efforts and their capacity to serve their broader communities.[22] Robust community engagement may help overcome these barriers, promote a deeper and more meaningful understanding of SDOH and promote overall success of a program.

Community engagement also is fundamental to ensure that policies are designed alongside the individuals and communities they are intended to serve. All too often, policies are developed without the wisdom and insights of those most directly impacted, especially those from groups that have been historically

marginalized and disproportionately burdened with worse health outcomes. Inclusion of these community voices ensures that SDOH programs ultimately reach those who can most benefit in a manner that matches their needs and preferences, while fostering greater community ownership.

Many state Medicaid agencies appreciate the import of community engagement, but find it challenging to implement, as CBOs do not typically have associations representing their interests in the same way that health care organizations do. CCHs can be valuable partners to support state Medicaid agencies' efforts to engage communities, particularly by 1) supporting relationship-building among key players and 2) integrating authentic community voices and equity principles into all stages of planning and implementation.

State Strategies to Engage Communities via CCHs

1. **Support relationship-building among key players**. CCHs are natural conveners, able to tap into existing relationships to cultivate trust and alignment for long-term, effective partnerships.
   - Convene CCHs and their CBO networks, health care organizations and other community partners (such as trade association leaders and social health platform vendors, if applicable) for planning, information sharing and relationship-building.
   - If a CCH does not exist in a particular market, engage diverse stakeholders to determine if a CCH model is the desired approach for that community.
   - Promote the value proposition of CCH/CBOs to health care organizations, including their unique expertise in social care and community relationships and potential impact on health outcomes.
   - Collaborate with CCHs to help develop, or leverage existing, community mapping exercises that highlight CBO resources and identify potential gaps.
2. **Integrate authentic community voices and equity principles into all stages of planning and implementation**. CCHs can help ensure the inclusion of marginalized populations and organizations with diverse leadership as partners in the design and implementation of SDOH initiatives. CCHs may be

CCH Spotlight: Washington's ACHs' Community Engagement

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)

particularly helpful in establishing meaningful feedback opportunities of community members to support community trust, program uptake and nimble, ongoing program implementation, enabling initiatives to adapt as they play out on the ground.

- Embed CCHs and other community representation in state planning, design and implementation bodies.
- Leverage CCHs to help solicit broad public comment on program design or deliverables.
- Support cross-sector learning networks, including live feedback loops on program deployment.
- Ensure that participating organizations (including CCHs, their CBOs and health care organizations) reflect the community served in their own staffing and leadership, and in governance structures (e.g., board membership, community advisory boards, designated community liaisons, etc.).

Additional Resources: Oregon's Support of CCOs' Community Engagement

Using Section 1115 waiver authority, Oregon administers its Medicaid program through coordinated care organizations (CCOs)—networks of health care providers (physical health, mental health and dental) working together to address Medicaid members' needs. CCOs are provided global budgets and encouraged to provide health-related services (e.g., nutrition and housing services, as well as community benefit initiatives) to their Medicaid members to help address SDOH and advance health equity.

To ensure meaningful community engagement, Oregon requires its CCOs to establish a community advisory council (CAC) that is designed to play a central role in decision-making related to SDOH and health equity. Oregon provides support and learning opportunities to CCOs and CACs, including a "CAC Handbook of Best Practices" and a "CAC Member Recruitment Resource Guide"; details strategies to strengthen CCO/CAC partnerships in its "Policies Impacting CCO Community Advisory Councils (CACs)"; and requires CCOs report on CACs' membership diversity according to a guidance and template.

2: Expand Community Capacity

CCHs and their network CBOs operate on narrow margins and are often stretched meeting the significant needs of their existing clientele. Especially at an initiative's start-up, CCHs and CBOs may need additional resources to enter into new contractual relationships and prepare for an increase in demand for services, as referrals from new sources bring additional community members to their doors. For example, CCHs and CBOs may need to modify organizational processes, upgrade infrastructure and add to and train their workforce in preparation for new tasks and roles. See Chart 1 below for a more detailed description of start-up activities for CCHs and CBOs. At the same time, health care organizations also may need technical assistance in preparation for working with CBOs, including embedding the principles of cultural humility, diversity, equity and inclusion into their policies and processes, cultivating trusting relationships with community partners and helping to bridge the different cultures and expertise between the health and social sectors.

State Medicaid agencies can significantly expand community capacity by: 1) providing up-front funding to support CCHs and CBOs and 2) supporting training and technical assistance (TA) to CCHs, their CBO network and partnering health care organizations.

Strategies to Expand Community Capacity via CCHs

1. **Provide up-front funding to support CCHs and CBOs.**
   - Leverage Medicaid funding to invest in CCHs' and CBOs' up-front costs, including through:
     - Medicaid managed care:
       - Requiring or encouraging plans to invest profit or Medical Loss Ratio rebate funds into community initiatives
       - State-directed payments, which allow state Medicaid agencies to direct specific payments made by managed care plans to providers under certain circumstances
     - Section 1115 Demonstration Waiver

CCH Spotlight: Leveraging 1115 Waiver Authority to Expand CCH and CBO Capacity

North Carolina's 1115 waiver-authorized "Healthy Opportunities Pilots" rely on three regional CCHs (called "Network Leads"), each contracting with the state's managed care plans and coordinating a network of CBOs to deliver housing, food, transportation and interpersonal safety-related services to the plans' eligible enrollees. The state allocated up to $100 million of Medicaid funding available for the Pilots for Network Lead and CBO capacity building. In its Network Lead RFP, North Carolina defined permissible uses of capacity building funding for both entities and required the Network Leads to distribute at least 51% of their capacity building funds to their CBOs.

New York requested in its pending 1115 waiver amendment 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.

- Collaborate with CCHs to identify non-Medicaid federal, state, local and private philanthropy sources that can complement Medicaid funding
- Leverage CCHs to deploy the capacity expansion investments in the CBO network, including:
  - Managing the distribution of the funding
  - Monitoring the use and impact of the investments
  - Ensuring equitable allocation of capacity building funds, including sufficient funding for smaller or under-resourced CBOs

Additional Resources: Leveraging 1115 Waivers to Expand Capacity for CBO-Health Care Partnerships

- **Oregon's** 1115 waiver allocates $119 million for infrastructure investments to support the development and implementation of health-related social need services.
- **Rhode Island** intends to use $3.5 million of its 1115-waiver approved "Health System Transformation Project" resources for an SDOH Investment Strategy to build capacity among the state's Medicaid Accountable Entities (Medicaid accountable care organizations) to collaborate with CBOs to address health-related social needs.

2. **Support training and technical assistance (TA) to CCHs, their CBO network and partnering health care organizations.**
   - Collaborate with CCHs to assess TA needs (for CBOs that are part of the network, and partnering health care organizations) and design tailored curriculum including, for example:
     - Policies, processes and expectations for program participation
     - Onboarding and use of data collection or exchange systems
     - Trauma-informed care
     - Cultural humility, diversity, equity and inclusion
     - Budgeting/financial management
     - Data privacy and handling sensitive data
   - Leverage CCHs to:
     - Provide the TA and trainings
     - Serve as a learning collaborative convener across network CBOs and health care partners

Additional Resources: States Supporting CBO Training and Technical Assistance

- **California**, through its Providing Access and Transforming Health (PATH) Supports initiative, will be launching a TA marketplace, convening regional collaborative planning efforts and providing funding to support capacity and infrastructure for CBOs. Additionally, the Incentive Payment Program (IPP) will support capacity building for Enhanced Care Management and Community Supports.
- **Massachusetts,** under its 1115 waiver Delivery System Reform Incentive Payment (DSRIP) program, provided technical assistance to ACOs, Community Partners and Community Service Agencies (specific group of community behavioral health providers) to support workforce and infrastructure through the Massachusetts Technical Assistance Marketplace (TA Marketplace), a website designed for the participating entities to access trainings and apply for technical assistance support. The website includes both off the shelf trainings and a catalog of vendors.

Chart 1: Possible Start-up Activities for CCHs and Their Network of CBOs

Possible Start-Up Activities for:	
CCHs Engaging in a State Medicaid Initiative	**CBOs in the CCH Network**
• Evaluate what modifications to existing services, workflows and workforce are necessary to meet the initiative's expectations • Develop the CBO network (or tailor their existing CBO network, if applicable)—including conducting outreach to CBOs that may be eligible and qualified to join the network; assessing potential organizations' qualifications; and dedicating legal resources to contract with qualified organizations • Manage the CBO network—including providing expertise and guidance to CBOs; troubleshooting issues; improving CBOs' performance over time; and maintaining contracts over time • Develop relationships with the health care organizations that will utilize their CBO network for the specific state program and dedicate legal resources to contracting with them, both at the point of establishing contracts and while maintaining them • Participate in and convene learning collaboratives to build and enhance relationships among CCHs, their network CBOs and health care entities • Establish new or upgrade existing IT systems and workflows to engage in data exchange with health care entities	• Evaluate what modifications to existing services, service delivery workflow and workforce are necessary to meet the initiative's expectations and anticipated increased demand for their services • Dedicate legal resources to contracting with the CCH • Devote staff time to attend program orientation, trainings and learning collaboratives • Prepare staff and resources for increases in service delivery and adapt workforce and workflow processes to these increases • Establish new or upgrade existing IT systems and workflows to engage in data exchange with health care entities

3: Promote Operational Excellence

Cultivating productive and equitable partnerships between CBOs and health care entities requires not only mission alignment and trust, but infrastructure and business practices that promote operational excellence—including efficiency and accountability between organizations, shared infrastructure and high-quality services. In particular, the following building blocks can help establish efficient working relationships and operational excellence:

- **Clear, Written Understanding of Roles and Responsibilities**. Written agreements help to solidify roles, establish accountability and develop a sense of ownership among partners.[23] According to a 2017 study, many CBO and health care partnerships are not formally memorialized through written documentation, and when they are, they often lack legally binding terms and conditions.[24] Tools, such as a roles and responsibilities matrix, also may be helpful to clarify expectations among partners.[25]
- **Standardization, When Appropriate**: Standardizing certain features of CBO-health care partnerships—such as data exchange standards and metrics for oversight and evaluation—supports equitable delivery of high-quality services, increased accountability and more meaningful evaluations. Standardization can also streamline processes (and lower costs) for CCHs and CBOs collaborating across multiple health care organizations. At the same time, as underscored by the COVID-19 pandemic, policies and programs must also allow for flexibility to respond to community needs in the face of unexpected challenges, including workforce shortages and unexpected or traumatic events in the community (e.g., violence and natural disasters).[26,27] Inflexible policies and funding have been shown to disproportionately adversely affect organizations led by people of color, which generally receive less and more restrictive funding than white-led organizations.[28,29]
- **Efficient and Shared Data Infrastructure**. The lack of a standardized approach to data collection and bidirectional data exchange between the health care and social service industries is particularly challenging for efficient program implementation and outcomes-driven evaluation.[30,31] Health care and CBO partners have different technological capabilities and systems, different federal and state laws that govern their industries, as well as varying data privacy concerns that need to be reconciled to enable bidirectional data exchange and ultimately provide individuals the care and services they want and need. For example, CBOs providing interpersonal violence (IPV)-related services with funding authorized under the Violence Against Women Act, the Victims of Crime Act and/or the Family Violence Prevention and Services Act Program are subject to strict privacy and confidentiality requirements[32,33] that differ significantly from HIPAA protections. Having common data-sharing platforms that reconcile these differences can help promote consistency, improve coordinated referrals and enhance data collection to assist service payments and evaluation.

Strategies to Promote Operational Excellence via CCHs

1. **Ensure key players have a clear understanding of each other's roles and responsibilities**. CCHs can help establish formal agreements between their CBOs and health care organizations that provide accountability for all involved.
   - Collaborate with CCHs to develop a common description of key entities' roles and responsibilities.
   - Encourage the use of written contracts between health care partners and CCHs, as well as between CCHs and their network CBOs.
   - Consider working with CCHs to leverage existing contracts or develop model contract language that the health care and CBO organizations can use to formalize contractual arrangements.

CCH Spotlight: North Carolina Model Contracts for CCH

North Carolina collaborated with its "Healthy Opportunities Pilots" Network Leads and managed care organizations (MCOs) to develop model contracts to support Network Lead-MCO and Network Lead-CBO contracting.

Additional Resources: Massachusetts Community Partner Program Guidance

Massachusetts operates, under an 1115 waiver, the Behavioral Health (BH) and Long-Term Services and Supports (LTSS) Community Partners program, in which community-based entities work with accountable care organizations (ACOs) and managed care organizations (MCOs) to provide care management and coordination to certain Medicaid members. To support program implementation, Massachusetts published detailed guidance for ACOs, Community Partners and Community Service Agencies (specific behavioral health providers) on entity responsibilities, funding and payment details, and process flows.

2. **Balance the need for standardization and accountability with flexibility to adapt to community needs**. CCHs can help inform decisions that preserve trust among partnering entities.
   - Consider with CCHs and other potential partners whether and how to standardize design features, such as:
     - The priority SDOH domains and health-related services that CCHs' CBOs will deliver to program participants
     - Service payment methodologies and rates
     - Criteria for individual CBO participation and for the CBO network as a whole
     - Quality and accountability metrics for CCHs, network CBOs and partnering health care organizations that measure program impact and compliance
   - Build flexibility into program design to allow for regional or community variations.
   - Collaborate with CCHs to develop transparent communication channels and decision-making processes to learn about and respond to on-the-ground experiences and community needs.

3. **Support the development of the IT and data exchange infrastructure needed for service referrals, payment, program monitoring, evaluation and oversight**. CCHs can help design and implement data-sharing across CCHs, their network CBOs and partnering health care organizations.
   - Collaborate with CCHs to develop and implement data sharing and IT priorities that:
     - Help establish data collection, transmission and use standards, including:
       - Data sources, systems of truth and entity resolution
       - Linking data across entities through common individual identification and indexing (e.g., identity management)
       - Data extraction and aggregation
       - Standardization of core data elements and definitions
       - Data repositories and storage
       - Data governance
       - Data quality
       - Data security
       - Privacy and security, consent and the appropriate uses of data
       - Reporting templates
     - Consider what data-sharing platform(s) or tools will be used by CBOs and health care partners, including, for example:
       - Health information exchanges (HIEs) and community information exchanges (CIEs)
       - Identity management and directories
       - Care management and consent management tools
       - Closed loop referral systems
       - Network management platforms
       - Invoicing and payment systems
       - Data analysis, reporting and visualizations
     - Ensure adequate onboarding and training resources for all required participants
   - Leverage Medicaid IT funding and other state/federal/private funding opportunities to financially support the data-sharing and IT agenda noted above (see Appendix A for potential Medicaid funding authorities)

Additional Resources: State Strategies Supporting Data Exchange for CCHs and CBOs

- **Arizona**: As part of its Whole Person Care Initiative (WPCI), Arizona partnered with the state's health information exchange (HIE), Contexture, and 2-1-1 Arizona to implement CommunityCares, the statewide SDOH Closed Loop Referral System.
- **California**: California launched CalAIM Data Sharing Authorization Guidance to encourage data sharing among health care, community-based and public agencies that manage care under CalAIM. California is also developing a draft Universal Authorization for Release of Information form to establish a standardized data exchange process to promote patient consent management.
- **New York**: In its proposed 1115 waiver amendment, Social Determinants of Health Network (SDHN) regions will be permitted to use different referral platforms and data systems to support a state standardized social needs screening and referral process that must be qualified to be interoperable. These systems will feed into a statewide data store supported by the existing infrastructure of the Statewide Health Information Network for New York (SHIN-NY).
- **New Jersey**: New Jersey appropriated state dollars to regional entities recognized as Medicaid ACOs under the NJ ACO Demonstration Project (2015-2019). ACOs could use funding toward the development and maintenance of regional health information platforms. In 2020, these ACOs were replaced by legislation recognizing these entities as regional health hubs and requiring them to "establish, operate and maintain" health information platforms.
- **North Carolina**: North Carolina established "NCCARE360," a statewide resource and closed loop referral platform that supports the Medicaid "Healthy Opportunities Pilots" through enabling referrals for Pilot health-related services to Pilot-participating CBOs, tracking Pilot enrollment and Pilot service utilization, assessment of network CBO performance and submission of Pilot service invoices to MCOs.

4: Create Pathways to Financial Sustainability

To sustain SDOH interventions, CBO-health care partnerships need to be financially viable over the long term. Achieving long-term sustainability can be challenging for various reasons:

- **Historic underfunding of social care**. CBOs are often cobbling together a variety of time-limited, grant-based resources (including from private foundations, health care payers or providers and various federal, state or local government entities), making it challenging to accumulate reserves or invest in infrastructure (i.e., IT and data analytics).[34,35]
- **Complexities of integrating two industries that are financed differently**. Most CBOs do not think about revenue in the same way health care organizations do (i.e., fee-for-service versus capitation) or price their services based on volume (integrating fixed versus variable costs).[36],[37] CBOs and health care organizations alike may face challenges in precisely predicting the changes in health outcomes, utilization and health care costs that determine the "return on investment" (ROI) from the program—though tools to support this ROI calculation may help.[38,39] Additionally, financial arrangements are complicated by "wrong pocket" challenges—where savings from investment accrue to other players or sectors.
- **Emergent Evidence Base**. While the evidence base on the impact of health-related interventions continues to grow, state Medicaid agencies and participating organizations may lack the infrastructure, expertise or funds to conduct rigorous evaluations of all the key inputs and outcomes of SDOH partnerships.[40] As a result, the current evidence base reflects more discrete studies of very specific interventions, typically focused on individuals with high costs and high needs and often reliant on process outcomes (e.g., patient satisfaction or self-report data).[41] More rigorous evaluations can help refine selection criteria for the intervention population, more precisely scope the evaluation, and interpret results to consider different applications of an intervention[42] as well as identify which interventions can be scaled for a wider array of people and the interventions' impacts—on a broader range of outcomes. For example, some interventions may not save costs, particularly in the short term, but are valuable because they improve equity, health and well-being.[43]

While establishing CCHs can require up-front investment, they can also help state Medicaid agencies support the sustainability of CBO and health care partnerships by: 1) providing adequate reimbursement for health-related services; 2) collaborating with other federal, state, local and non-profit/private organizations to supplement Medicaid resources; and 3) supporting evaluation frameworks and outcome measurements to identify long-term value.

Strategies to Create Pathways to Financial Sustainability via CCHs

1. **Provide adequate reimbursement for health-related services.**
   - Leverage Medicaid to pay for health-related services, including through State Plan benefits (e.g., case management), 1915 waivers (e.g., home accessibility modifications permitted in 1915(c) waivers), flexibilities in managed care arrangements (e.g., medically tailored meals as an "in lieu of service") and 1115 waivers (see Appendix A for a detailed review of authorities that can be used to cover various types of health-related services).
   - Leverage CCH and community input to support appropriate and equitable CBO payment rates by, for example:
     - Reviewing proposed CBO payment rates against industry standards and anticipated demand for covered services to ensure CBOs' revenue will support long-term participation in the partnership
     - Ensuring CCHs' and CBOs' administrative and operational costs are included in payment rates
     - Supporting the development of a standardized "fee schedule," which could include fee-for-service payments, bundles of services paid in per-member-per-month arrangements or other payment methods
   - Ensure CCHs have access to necessary data, tools, expertise, and funding to support their CBO sustainability planning (e.g., providing de-identified state data, permitting use of up-front funds to hire vendors to conduct analysis).

CCH Spotlight: New York's Pivot to CCHs

Since 2018 New York has required its managed care organizations' upside and downside risk VBP arrangements to include at least one SDOH intervention and a contract with at least one community-based provider. As described in the pending 1115 waiver amendment, New York now seeks to draw on the successes and challenges of CBO integration to establish regional Social Determinant 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 (SCN) that will improve health outcomes. SDHNs will pay their network CBOs for services delivered via a fee schedule through advanced VBP arrangements or other provider contracts.

Additional Resources: California Embeds Services in Managed Care Delivery System

California Advancing and Innovating Medi-Cal (CalAIM) is California's plan to transform the Medicaid Program (Medi-Cal), including by embedding services to address health-related social needs within the Medicaid managed care delivery system. This includes:

- **Enhanced Care Management**: A new benefit in which a single lead care manager coordinates care and services across the physical, behavioral, dental, developmental and social services delivery systems for the highest-need enrollees; authorized under the state's 1915(b) waiver.
- **Community Supports**: New statewide services that are cost-effective alternatives to traditional services or settings—also known as "in lieu of services" (ILOS)—designed to address the health-related non-clinical social needs of Medi-Cal members. As ILOS, these services count toward plans' requirements to spend the vast majority of their funding on improving health (rather than administrative expenses). Most Community Supports are implemented under the managed care ILOS authority, though some are authorized through a combination of the state's 1115 and 1915(b) waivers. All Medi-Cal managed care plans are encouraged to offer as many of the 14 pre-approved Community Supports as possible and are required to partner with provider organizations (including CBOs) to provide them.

2. **Collaborate with other federal, state, local and non-profit/private organizations to align resources**. State Medicaid agencies can play an important role in coordinating with other agencies that share their goals, identifying opportunities to blend and braid funding.
   - Leverage CCHs' knowledge of diverse funding resources—particularly local philanthropies and programs—to align Medicaid investments with other sources of private funding.
   - Identify opportunities to work across state programs, to more broadly integrate and align a variety of funding, agency guidance and program implementation resources to advance shared health and wellness goals.

CCH Spotlight: Collaborative Funding Leveraging Hubs

- **Ohio HCBS Waivers and Area Agencies on Aging (AAA)**: Ohio has 12 AAAs that serve different regions of the state, providing supports to older adults living in their homes or other settings of choice. The AAAs receive a blend of funds to support their work, including federal, state, local and community funds and contributions. Ohio's managed care contract for dual-eligibles requires Ohio's Medicare-Medicaid Plans, called MyCare Ohio plans, to contract with the state's AAAs for coordination of home and community-based services (HCBS) under their 1915 waivers for individuals aged 60 and over.
- **National Diabetes Prevention Recognition Program and Umbrella Hub Arrangement**: The CDC's National Diabetes Prevention Recognition Program awards recognition to CBOs and other entities that meet national standards to prevent or delay the onset of type 2 diabetes as part of the National Diabetes Prevention Program (DPP) Lifestyle Change Program. State Medicaid agencies have begun leveraging the CDC's investment in these organizations by supporting partnerships between MCOs and CDC-recognized entities through 1115 waivers, state plan amendments and other Medicaid demonstration projects. To further support sustainability, the CDC recently developed the Umbrella Hub Arrangement model, which organizes a network of CDC-recognized CBOs under a lead organization that helps to connect the CBOs to health care payment systems and establish streamlined infrastructure for billing, claims and other administrative support.

Additional Resource: Louisiana's Collaborative Funding Approach to Housing

Louisiana's Permanent Supportive Housing (PSH) Program combines permanent, subsidized rental housing with flexible, individualized housing and tenancy supports for individuals who have significant long-term disability, are receiving Medicaid or Ryan White services and meet income requirements. The program was borne from collaboration between the Louisiana Department of Health (Medicaid agency), Office of Aging & Adult Services, the Louisiana Office of Community Development, the Louisiana Department of Children & Family Services, the Louisiana Housing Corporation/Housing Authority, and advocates for people with disabilities and experiencing homelessness. Funding for the program is braided across various sources, including: Low Income Housing Tax Credit Program (LIHTCP), rental subsidies (such as Continuum of Care (Shelter Plus Care), Section 811 Project Rental Assistance Program), 1915(c) Home and Community-Based Services waiver, Medicaid State Plan, Ryan White, Cooperative Agreement to Benefit Homeless Individuals, Veterans Services, and Community Development Block Grant.

3. **Support evaluation frameworks and outcome measurements to identify long-term value**. State Medicaid agencies have an opportunity to collaborate with CCHs to develop well-planned and methodologically sound evaluations, which can add to the evidence base on the short-term and long-term impacts of CBO relationships and SDOH interventions.
   - Collaborate with CCHs on the approach to evaluation, including on:
     - Potential third-party evaluators
     - Identifying metrics to measure quality impact inclusive of but beyond ROI—including process and outcome measures and other quality and accountability metrics—and mobilizing support toward advancing progress on these metrics
     - Identifying how partnering entities can report the necessary data to support evaluation of these metrics
   - Work with CCHs to develop dashboards or reports that provide partnering entities with visibility into program impact and evaluation findings.
   - Provide CCHs, evaluators and other entities, when appropriate, with access to Medicaid and MCO service utilization data to support partnership assessments on outcomes and cost savings.

Additional Resources: Relevant Evaluation Examples and Resources

Innovative state efforts to support evaluation

- **New Jersey**: The New Jersey Integrated Population Health Data Project (iPHD) is a collaboration among the New Jersey Department of Health, Department of Human Services (including Medicaid), other state departments/agencies, universities and members of the public that facilitates access to integrated data from different governmental entities to promote research that may be used to support research design, implementation and evaluation of population health programs. Current research priorities include SDOH's and whole person care, improving maternal and child health outcomes, addressing the opioid epidemic, and responding to COVID-19 and other public health emergencies.

Social Interventions Research & Evaluation Network (SIREN)

- Housed at the Center for Health and Community and the University of California, San Francisco and supported by Kaiser Permanente and the Robert Wood John Foundation, SIREN is a network that seeks to accelerate high-quality research through innovation grants; collect, summarize and disseminate research and findings; and increase researl standardized the font treatment accross all boxes so that they are more consistent in ch capacity by providing consulting services to safety net and mission-aligned health systems. Social Interventions Research & Evaluation Network (SIREN) Evidence and Resource Library includes peer-reviewed publications and other types of resources building the evidence base for medical and social integration.

Examples of evaluation designs and reports for Medicaid programs that integrate CBOs into the health care continuum:

North Carolina: Evaluation design for "Healthy Opportunities Pilots"

Washington: Evaluation design for "Accountable Communities of Health" and Interim evaluation report

Massachusetts: Evaluation design for investments in "Community Partners" and "Flexible Services" and Midpoint assessment

5: Look Upstream

State Medicaid agencies seeking to address SDOH and health equity have an opportunity to contribute to larger collective efforts to invest in the communities in which they operate. Providing a food box addresses an individual's immediate food insecurity; rooting that service in larger efforts to ameliorate food desert conditions can be even more impactful. Indeed, a recent randomized control evaluation has underscored that even achieving progress on metrics such as hospital readmissions may be challenging without serious investments and policy shifts that address structural inequities and historic divestments in social and economic opportunities for the communities served.[44,45,46,47]

Addressing upstream factors cannot be achieved by a single agency or single intervention, but rather requires the collective efforts of various stakeholders coming together and committing to long-lasting transformation. With their diverse network of CBOs and partners with deep ties to communities, CCHs can help state SDOH initiatives to contribute to efforts to revitalize communities and invest upstream. The strategies discussed in this Playbook can be strengthened when state Medicaid agencies, CCHs and other federal, state and community partners come together, keeping the following principles in mind.

- **Community revitalization is key to achieving health equity**. Health equity requires the collective efforts of stakeholders to revitalize communities overall, including investments in housing, schools, transportation and civic societies now and for future generations. A resilient civic culture is made of individuals who not only feel ownership of their own health and well-being, but feel responsibility and civic duty to take care of the health and well-being of their communities, and feel empowered to re-imagine healthier, safer, more vibrant communities and advocate for change.[48,49,50,51] Research shows that civic participation improves health by enhancing social capital and mitigating social isolation.[52,53]
- **Addressing racism is central to health equity and addressing SDOH**. Structural racism has led to myriad barriers to accessing health care and direct adverse health outcomes for people of color.[54,55,56] Health equity policies and programs that acknowledge the specific role of racism as a root cause can better understand present health inequities, associated traumas, resulting disparities in health outcomes and continued challenges that health systems face in developing trust and meaningful relationships with people of color.[57] CCHs may play a valuable role in helping the collective recognition of racism as a driver of health by grounding policies, practices and communications in diversity, equity and inclusion (DEI) principles and ensuring that governance structures are representative of the communities served.
- **Health equity and SDOH solutions require a resilient and diverse workforce**. Public policies and programs, including those focused on health, require a strong workforce. Unfortunately, the pandemic has left in its wake provider shortages and burnout.[58,59] Research also highlights that concordance between provider and patient racial, ethnic, linguistic and cultural identities in health care leads to increased trust and better quality of care—patients do better when the workforce looks like the patients it serves.[60]

The strategies described in this Playbook can be better achieved when an array of federal, state and local stakeholders—including Medicaid agencies and CCHs—come together to align SDOH initiatives with efforts to address the upstream contributors.

Chart 2: Connecting the Dots—Taking an Upstream Approach

Upstream Focus: How CCHs can help state Medicaid agencies look upstream	
Engage communities	• Gather input from the community to inform and implement community revitalization and re-investment efforts and promote civic engagement among its CBO network, partnering health care organizations and the communities served. • Create an opportunity for health care entities to strengthen DEI approaches to their organizational structure, care delivery models and partnerships, all of which will enhance trust and deepen relationships with the communities.
Expand community capacity	• Promote a robust and diverse workforce by, for example, participating in workforce pipeline programs focused on BIPOC communities; offering professional development opportunities for its CBO network and partnering health care organizations; and the recruitment of community health workers (CHWs), who can serve as important connectors between the health care system and community resources, building trust with communities who often experience distrust in the health care system.
Create pathways to financial sustainability	• Identify and mobilize diverse financial resources to not only support their specific interventions but to invest in the broader ecosystem in which their initiatives operate. • Use their broad base to advocate for policy changes needed to promote structural reforms and build community wealth. • Help design and implement evaluations that develop more nuanced return on investment models that contemplate the value of interventions to communities, promoting overall health and well-being, and advancing equity.

Additional Resources: Oregon's Commitment to Upstream Efforts

Oregon has long demonstrated its commitment to addressing not only individuals' health-related needs but also community-level health. Oregon's Coordinated Care Organizations (CCOs) are encouraged to provide health-related services, including "flexible services"—which are offered to individual members to supplement covered benefits—and "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.

Additionally, as part of the "Supporting Health for All through Reinvestment (SHARE) Initiative," CCOs are required to invest a portion of the plan's previous year's net income or revenues on services to address health inequities and the social determinants of health and equity (SDOH-E). SHARE spending must fall into one of four domains: economic stability, neighborhood and built environment, education, and social and community health—though a portion must be on housing-related services and supports.

Finally, the agency's Maternal and Child Health (MCH) Section has articulated its commitment and vision for racial equity and in 2017 published an MCH Racial Equity Policy. The MCH website has several tools to promote racial equity, including a racial equity assessment and action plan and offers compiled resources related to implicit bias, health literacy, and cultural and linguistic services (CLAS) standards.

Additional Resources: States Requiring MCO Investment in Communities

The following states have directed or encouraged MCOs to reinvest a portion of revenue or profits into the communities they serve:

Arizona requires MCOs to invest six percent of annual profit into community-based initiatives (section D of managed care contract), submit a plan detailing its anticipated activities (including expected beneficiaries and how they will benefit), and report activities to the State in compliance with the Community Reinvestment Policy, the Community Reinvestment Plan Template (Attachment A), Community Reinvestment Report (Attachment B).

Nevada is proposing in its re-procurement RFP to require MCOs to invest three percent of pretax profits into the community being served. MCOs are required to submit a plan to the state detailing the anticipated community reinvestment activities.

North Carolina encourages health plan reinvestment into the community by allowing plans that fail to meet the medical loss ratio (MLR) standard to invest dollars they otherwise would need to rebate to the state in activities to address social drivers of health. Health plans that proactively reinvest in the community served also may be rewarded with a one percent bump in their auto-assignment algorithm.

See more about **Oregon's** "Supporting Health for All through Reinvestment (SHARE) Initiative" in the call-out box above.

Tennessee is proposing in its re-procurement RFP to require MCOs to commit to a level of community reinvestment spending as part of their application response, which will convert to the MCO's minimum community investment requirement annually thereafter. RFP respondents will be scored on their level of community investment commitment.

Conclusion

As state Medicaid agencies increasingly seek to address individuals' and families' health-related social needs, CCHs are emerging as important partners in integrating social care and community voices into the health care continuum. Working with CCHs—or helping to form new CCHs—requires investment of time and resources. However, when well executed, the CCH model holds promise for supporting state Medicaid agencies to more effectively and sustainably deliver whole person care.

Appendix A: Medicaid Authorities to Support Financing of CCHs

Funding Use	Potential Medicaid Authorities to Support Funding Use
Capacity building	• Section 1115 Demonstration Waiver: Offers authority to pay for expenditures and services not otherwise covered under Medicaid; must advance purpose of Medicaid and be budget-neutral.
Coverage of Health-Related Services	• **State Plan**: States have discretion to offer a range of social services as Medicaid plan benefits, though some authorities or specific benefits may be limited to a subset of higher-need Medicaid enrollees: – Section 1905(a) and 1915(g): "Case management" and "targeted case management," which pays for the cost associated with helping enrollees gain access to medical, social and educational services; – Section 1905(a): "Preventive" and "Rehabilitative" services, which may be used to cover medical and remedial services recommended by a physician but provided by community health workers or peer specialists, including navigating the health care system and connecting with CBOs;[61,62] – Section 1915(i): Home and community-based services (like those permitted in 1915(c) waivers—below) for individuals who meet less stringent criteria than institutional criteria needed for 1915(c) waivers; – Section 1915(j): "Self-directed personal assistance services," which can cover items that increase an individual's independence or substitute for human assistance (e.g., microwave oven, grab bars); – Section 1915(k): "Community First Choice" benefits, which offer personal attendance services and supports in a home and community-based setting; and – Section 1945: "Health home" services, designed to provide "whole person" care including comprehensive care management, individual and family support and referrals to community and social support services. • **Waivers**: – Section 1115 Demonstration Waivers (see description above). – Section 1915(c) Home and community-based waiver: Allows states to offer long-term services and supports in home and community-based settings to individuals who would otherwise require institutional care, including home accessibility adaptations, housing and tenancy supports, non-medical transportation and others. • **Medicaid managed care financing tools**: – 1915(b)(3) services: Allow states to share savings resulting from the use of more cost-effective care in the form of additional health-related services, for 1915(b) waiver enrollees. – In-lieu of services (ILOS): Managed care plans may cover services or settings that are "in lieu of" services or settings covered under the state plan if medically appropriate and a cost-effective substitute for the covered service. – Value-added services: Managed care plan may voluntarily cover services that are in addition to those covered under the state plan; the cost of these services is excluded from capitation rates.

Funding Use	Potential Medicaid Authorities to Support Funding Use
Data Integration and Information Sharing	• Medicaid administrative funds: – Enhanced federal Medicaid matching funds are available (at 90 percent) for state expenditures to design, develop, install or enhance Mechanized Claims Processing and Informational Retrieval Systems and (at 75 percent) to operate such systems, including for data integration and sharing to identify individuals with health-related social needs and to link them to appropriate medical and social support services; systems must meet interoperability and cost allocation standards, which states must detail in a Health Information Technology Implementation Advanced Planning Document (HIT IAPD) for CMS.[63]
Flexible Use	• Medicaid managed care financing tools that could be designed to support activities across the above categories: – Requiring or encouraging plans to invest profit or Medical Loss Ratio rebate funds into community initiatives. – State-directed payments that allow states to direct specific payments made by managed care plans to providers under certain circumstances. – Incentive and withhold[64] payments: ▪ States may use incentive payments over and above their capitation payment for meeting contract targets, including, for example, investments and/or improvements in SDOH. ▪ Withhold arrangements include payment mechanisms under which a portion of a plan's capitation rate is withheld unless a plan meets performance targets. – Value-based payment strategies that support plan/provider investment in social interventions.[65] – Integrating efforts to address social issues into quality improvement activities.[66] – Rewarding plans through higher rates for effective investments in social interventions.[67]

Unless otherwise noted, funding authority information in Appendix A was sourced from: State Health Official Letter #21-001. Opportunities in Medicaid and CHIP to Address Social Determinants of Health. Centers for Medicare and Medicaid Services. January 2021.

Appendix B: Examples of CCHs

A CCH may take myriad forms, varying in structure, size, services provided through its network, funding sources, geographic reach, and roles and responsibilities. This appendix spotlights various hub models across the country.

Chart 3: Examples of How State Medicaid Agencies Have Either Leveraged 1115 Waiver or Managed Care Contracting Opportunities to Integrate CCHs Into the Health Care Continuum

Description of CCH model	Example(s)	Additional Notes and Resources
1115 Waiver Examples		
Washington State Accountable Communities of Health		
The Washington State Health Care Authority (HCA) established Accountable Communities of Health (ACHs) in 2015 through state legislation and a CMS State Innovation Grant and then further expanded them in the state's 1115 waiver approval (2017–2022) and extension. An ACH is designed to be "a neutral convener, coordinating body, investor and connection between the health care delivery system and local communities." As "independent regional organizations," ACHs work on "specific health care and social needs-related projects" to improve the health of their communities as a whole. ACHs must enable public-private partnerships focused on collaboration with representation across the health sector, community and consumers. Under this model, the state prioritizes regional flexibility and community-driven innovation. There are currently nine ACHs that contribute to driving Medicaid transformation by: • Partnering in procurement • Developing a regional health assessment and Regional Health Improvement Plan • Driving accountability for results through voluntary compacts • Acting as a forum for harmonizing payment models, performance measures, and investments • Promoting health coordination and workforce development	As the ACH for King County, HealthierHere is managed by a 27-member governing board, which includes providers and payers, government, community and consumers, tribes, and CBOs. HealthierHere brings health and social service organizations together to identify opportunities, co-design solutions and implement ways of delivering care that better meet the communities' needs. They are working to: • Design and implement transformation projects that target regional health care challenges, in partnership with clinical, community and tribal partners • Achieve targets and submit deliverables, as required by the Washington State Health Care Authority • Build regional capacity through regional investments (e.g., Health IT and training/technical assistance) • Distribute funds to partnering providers for achievement of defined milestones • Partner with community members to ensure community voice and equity are at the center of this work • Coordinate and oversee the work in partnership with local partner organizations HealthierHere resources: • Certification reports • Project plans • Implementation plan narrative • Semi-annual reports	• 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) • ACHs are focused on advancing health equity in various ways, including by developing a Community Health Fund to address SDOH-related issues, a Tribal learning series and A Consumer Voice Committee that developed an equity tool to assess impact and consumer voice. • Evaluation Resources: – Evaluation design for ACHs – Washington's Interim evaluation report – Center for Community Health: Evaluation of ACHs (2019)

Description of CCH model	Example(s)	Additional Notes and Resources
North Carolina Healthy Opportunities Pilots		
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. Network Leads play a critical role in each of the three geographic regions where the Pilots are operational, developing a CBO network that provides social services to eligible Medicaid managed care enrollees . North Carolina requires its managed care plans to contract with the Network Leads (Medicaid managed care contract, Amendment #7 (8)). Key Network Lead responsibilities, as outlined in the RFP, include: • Building and managing a high-quality network of CBOs • Contracting with all Medicaid MCOs for use of the CBO network • Strengthening the capacity of CBOs to participate in Medicaid, including by providing capacity building funds and technical assistance; and • Supporting CBOs in the invoicing and payment process	The following organizations are North Carolina's Network Leads: • Community Care of the Lower Cape Fear, whose Cape Fear HOP Network includes 50 organizations across six counties • Access East, whose network includes 11 organizations across nine counties • Impact Health, whose network includes 47 organizations across 18 counties	• North Carolina developed the "Healthy Opportunities Pilot Service Fee Schedule," which defines and prices non-medical services offered to eligible Medicaid enrollees and was developed based on community feedback via: – Expert Advisory Panel, including two meetings that were open to public participation – Request for Information, soliciting initial service descriptions and cost data to inform the Fee Schedule (in addition to feedback on overarching program design); included a "Cost Report Exercise Worksheet" – Draft Service Definitions and Pricing Inputs, released for public comment • The state allocated up to $100 million of Medicaid funding available for the Pilots for Network Leads and CBO capacity building. In its Network Lead RFP, North Carolina defined permissible uses of capacity building funding for both entities and required the Network Leads to distribute at least 51% of their capacity building funds to their CBOs. • "Healthy Opportunities Pilots" proposed design was published pre-implementation describing each entity's roles and responsibilities. • North Carolina collaborated with its Network Leads and managed care organizations to develop model contracts to support Network Lead-Health Plan and Network Lead-CBO contracting. • North Carolina established "NCCARE360," a statewide resource and closed loop referral platform that supports the Medicaid "Healthy Opportunities Pilots" through enabling referrals for Pilot health-related services to Pilot-participating CBOs, tracking Pilot enrollment and Pilot service utilization, assessment of network CBO performance and submission of Pilot service invoices to MCOs. • North Carolina developed infrastructure to receive encounter data for delivered Pilot services from its MCOs directly into its existing Medicaid system.[68] • Evaluation Resources: Evaluation design for "Healthy Opportunities Pilots."

Description of CCH model	Example(s)	Additional Notes and Resources
New York's Proposed Social Determinant of Health Networks (SDHNs)		
Under New York's 2014 1115 DSRIP waiver, the state established Performing Provider Systems (PPS), local collaboratives that formalized and connected regional networks of providers and CBOs that historically had not partnered with each other. Additionally, in 2018, New York required all of its managed care organizations' upside and downside risk VBP arrangements to include at least one SDOH intervention and a contract with at least one community-based provider. Building upon these earlier initiatives with an eye toward scalability and sustainability, New York's currently 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 (SCN) that will improve health outcomes. Key lead entity responsibilities include: • Formally organizing CBOs and supporting CBOs to build capacity and adopt and use technology, service delivery integration, workflows, and billing and payment systems • Coordinating a regional uniform referral system connecting CBOs with health systems, primary care, community and specialty behavioral health providers, care managers and other health care providers • Creating a single point of contracting for SCN interventions in VBP arrangements or with other providers • Advising on the best structure for screening Medicaid members using a standardized assessment tool for key SCN issues and making appropriate referrals	The below organizations are referenced in New York's pending 1115 waiver amendment as "developing SDHNs": • Healthy Alliance: An IPA devoted to addressing SDOH that currently relies upon a referral platform that is able to connect community members to over 580 Network partners (e.g., hospitals, schools, food pantries) • EngageWell IPA: An IPA established in 2017 by New York City non-profits, which had a long history of working together on the HIV/AIDS epidemic, and currently has 20 member organizations that collaborate with Medicaid managed care plans, ACOs and other IPAs to offer coordinated, integrated treatment options that include addressing SDOH	• New York requested in its pending 1115 waiver amendment between $92.5 million and $185 million per year for its SDHNs for initial network infrastructure, referral system, staffing, coordinated of CBOs, capacity building of CBOs and contracting. • SDHN regions will be permitted to use different referral platforms and data systems to support a state-standardized social needs screening and referral process that must be qualified to be interoperable. These systems will feed into a statewide data store supported by the existing infrastructure of the Statewide Health Information Network for New York (SHIN-NY).

Managed Care Contracting Examples
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 its dually eligible Medicare and Medicaid enrollees to contract with the state's AAAs to coordinate the home and community-based services (HCBS) provided under the 1915 waivers.
Indiana
• Indiana's Managed Long-Term Service and Supports RFP requires its managed care entities (MCEs) to contract with its current aged and disabled waiver care management entities (i.e., AAAs) and other independent care management providers for at least 50% of the plans' HCBS service coordination during the first two years of the program, after which they can either continue to contract services or submit a transition plan to the state.

Chart 4: National Models That Have Integrated CCHs Into the Medicaid Delivery System

Description of CCH model	Example(s)	Additional Notes and Resources
Area Agencies on Aging (AAA) and Centers for Independent Living (CIL) AAAs and CILs receive funding from the U.S. Department of Health and Human Services, Administration for Community Living (ACL) authorized under the Older Americans Act and the Rehabilitation Act and provide information and referral assistance, social care navigation services, and manage a local network of CBOs that deliver comprehensive community-based services to older adults and persons with disability. Over time, AAAs and CILs have evolved to form CCHs, which include a network of CBOs that come under the direction of a lead contracting organization. CCHs have developed increased capacity to manage multiple health care contracts as well as strengthened operational and administrative infrastructure to support management of health information, delivery of services, braiding of funding to finance services, billing and quality reporting. These hubs vary in structure, funding sources, geographic reach and services based on community need. Currently, ACL in collaboration with the CDC is supporting a National Learning Community with 58 emerging and expanding CCHs across 32 states that include aging and disability organizations and other lead entities collaborating to develop and/or expand as CCHs.	Examples: Below are examples of how AAAs have integrated into the Medicaid delivery systems: • The Virginia Area Agencies on Aging Cares (VAAACares) comprises 25 AAAs in Virginia and enables streamlined contracting with MCOs, offering a "one-stop shop for referrals, billing, reporting, data analytics, training, and quality assurance."[69] • A network of AAAs in Alabama provide community case management for a provider-sponsor primary care case management model that provides services statewide to nursing facility eligible Medicaid beneficiaries.[70] • In Massachusetts, AgeSpan is a designated AAA in northeast Massachusetts that supports partnerships between its network of CBOs and Medicaid managed care plans and Medicaid ACOs on initiatives focused on housing, care navigation and chronic disease. • Western New York Integrated Care Collaborative (WNYICC) is a multi-county network of over 30 member agencies that connects health care plans with two county-based AAAs, as well as a local United Way, and several neighborhood and regional CBOs.	• ACL's website on AAAs. • ACL's website on CILs. • Administration for Community Living. (2020, June). Strategic Framework for Action: State Opportunities to Integrate Services and Improve Outcomes for Older Adults and People With Disabilities. • Administration for Community Living. Contracting Spotlight. • Kunkel, S. R., Lackmeyer, A. E., Graham, R. J., & Straker, J. K. (2022, January). Advancing Partnerships: Contracting Between Community-based Organizations and Health Care Entities. J. K. Scripps Gerontology Center, Miami University. • Aging and Disability Business Institute, USAging and National Council on Aging. (March 2022). Success Stories Testing the Business Case: Can AAAs Provide Benefits Enrollment and Assistance in Partnership With Health Care Entities?

Description of CCH model	Example(s)	Additional Notes and Resources
Pathways HUB Model Developed over 20 years ago in Ohio, the Pathways Community HUB Institute® Model (PCHI® Model) is a data-driven model to identify and address social and health risk factors at the individual and community levels, ranging from postpartum services to housing and behavioral health services. Under the PCHI® Model, the Pathways Community HUB (PCH) entity is a neutral, accountable and transparent entity that hosts the network of care coordination agencies (CCAs) and provides the operating infrastructure. Pathways are the specific tools used by community health workers employed by CCAs to track an individual's identified risk factors through to a measurable outcome. As of October 2022, several counties in states across the country, including Ohio, Pennsylvania, Washington, Michigan, Wisconsin, Texas, and New Mexico, use the PCHI® Model. To become a PCH requires a formal certification process with the Pathways Community HUB Institute. **Elements of Pathways Hub:** The PCHI® Model is adaptable to meet the needs of different communities but requires meeting PCHI Prerequisites and core Standards as part of its national certification process, including on **infrastructure** (e.g., standardized data collection); **governance** (e.g., must have a community advisory council), **quality** (e.g., develop a quality improvement plan at care coordination and community level), and **sustainability** (e.g., relies on braided funding from multiple sources and must have contracts with at least two payers to be certified).	Established in 2007, the Northwest Ohio Pathways HUB was established to address high rates of low-birthweight births, especially among Black infants, in Toledo, Ohio, and the surrounding Lucas County. Over the years, the PCHI® Model has shown promise in reducing the rates of low-birthweight infants and infant mortality and also demonstrated success in coordinating care for chronic diseases among pregnant women with low income. In 2015, the Northwest Pathways HUB expanded beyond addressing low birthweight to address diabetes, heart disease and other chronic conditions in Lucas County. The Northwest Ohio Pathways HUB has various federal, state and other funding partners, including the CDC, Medicaid managed care organizations and local foundations. Established in September 2020, the 1889 Jefferson Center for Population Health launched the Community Care HUB (CCH) for Cambria and Somerset Counties in Pennsylvania to primarily serve pregnant women on medical assistance or any woman with gestational diabetes, and expanded services during the pandemic to families identified in need within county school systems. In 2022, CCH successfully contracted with health plan partners to reimburse the Community Care HUB network for engaging residents and successfully addressing their needs.	• Pathways Community HUB Institute website. Description of the PCHI Model. • Agency for Healthcare Research and Quality. (2016, January). *Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs and Improve Outcomes*. • Agency for Healthcare Research and Quality. (2016, January). Community Care Coordination Learning Network—The Pathways Community HUB Institute. Connecting those at risk to care: the quick start guide to developing community care coordination pathways. • Northwest Ohio Pathways HUB. • The 1889 Jefferson Center for Population Health Community Care HUB in Somerset and Cambria, Pennsylvania. • Goldman, TR. (2018, December). Charting a Pathway to Better Health. *Health Affairs*.

Description of CCH model	Example(s)	Additional Notes and Resources
National Diabetes Prevention Program Umbrella Hub Arrangements The U.S. Department of Health and Human Services, Centers for Disease Control and Prevention's (CDC) National Diabetes Prevention Program (DPP) is encouraging the formation of organized networks of CBOs that provide the National DPP lifestyle change program. Specifically, in 2020, the CDC piloted an Umbrella Hub Arrangement (UHA), comprised of a sponsoring hub (Umbrella Hub Organization) and participating CDC-recognized organizations that include CBOs (subsidiaries), which function as spokes to the hub. The UHA's primary goal is to help mitigate CBO reimbursement challenges by establishing a "cost-effective infrastructure to bill payers" on behalf of CDC-recognized organizations, which may facilitate contracting with health care payers and providers, achieving Medicaid provider status and/or meeting requirements set by accountable care organizations (ACOs), managed care organizations and other payers. In November 2021, CDC updated its UHA policies, which allow a single CBO to operate as an Umbrella Hub Organization, providing administrative functions that support individual CBOs delivering the diabetes prevention program under a single contract held at the administrative Umbrella Hub Organization.	Beginning in March 2020, CDC funded three organizations to operationalize UHAs through the Umbrella Hub Demonstration: • Hawaii Primary Care Association (PCA), a statewide network comprised of 15 community health centers focused on improving community health on a range of initiatives including the National DPP lifestyle change program. • Health Promotion Council, dedicated to promoting health and preventing and managing chronic disease among vulnerable populations. Since 2014, HPC partnered with the Pennsylvania Department of Health to strengthen the capacity of the National DPP. • Marshall University (West Virginia) implements the Appalachian Diabetes Control and Translation project, which seeks to prevent and manage diabetes by developing and offering technical assistance to coalitions providing the National DPP lifestyle change program in under-resourced rural counties across Appalachia and in various states.	• CDC DPRP Guidance Document • CDC's guidance for CDC-recognized organizations • CDC Customer Service Center: UHA Guidance and Application • National Association of Chronic Disease Directors (NACDD) and the Division of Diabetes Translation at the Centers for Disease Control and Prevention (CDC) created the National Diabetes Prevention Program Coverage Toolkit – Learnings from Umbrella Hub Demonstration – UHA One Pager, Terminology Guide, UHA FAQs – UHO Checklist, UHO Capacity Assessment, Tips for Creating UHO – Medicaid resources

Appendix C: State Strategies That Expand the Role of CBOs in the Health Care Continuum

This appendix highlights strategies that, while not always explicitly linked to CCHs, expand the role of CBOs in the delivery of care, which create supportive policy environments for the development of CCHs. Organized by the chapters in the Playbook, these charts provide examples that may be useful to state Medicaid agencies as they explore possible SDOH and health equity solutions.

Chart 5: Additional Examples and Resources When Integrating CBOs Into the Health Care Continuum

Strategy	Examples/Resources
Engage Communities	
1. Support relationship-building among key players	• **Massachusetts**: For its "Flexible Service Program", the Massachusetts Medicaid agency permitted the Accountable Care Organizations (ACOs) to use technical assistance funding to conduct research or hire a vendor to gain a better sense of potential Social Service Organization (SSOs) partners and conducted "101s" for ACOs on the housing and nutrition domains as well as the types of organizations offering these services. • **North Carolina**: Encourages Medicaid MCOs (section 8(e)(iii) of MCO contract) to use the State Center for Health Statistics' interactive "North Carolina Social Determinants of Health" map to strategically guide investments to address SDOH.
2. Integrate authentic community voices and equity principles into all stages of decision-making and accountability	• **Oregon**: To ensure meaningful community engagement, Oregon requires its coordinated care organizations (CCOs)—a network of health care providers (physical health, mental health and dental) working together to address Medicaid members' needs—to establish a community advisory council (CAC) that is designed to play a central role in decision-making related to SDOH and health equity. Oregon provides support and learning opportunities to CCOs and CACs, including a "CAC Handbook of Best Practices" and a "CAC Member Recruitment Resource Guide"; details strategies to strengthen CCO/CAC partnerships in its "Policies Impacting CCO Community Advisory Councils (CACs)"; and requires CCOs to report on CACs' membership diversity according to a guidance and template. • **CMMI AHC**: Publications advising on how to involve community members on CCH-like entities' advisory boards: – Summary of focus groups with advisory board members – Case study of advisory board collaboration
Expand Community Capacity	
1. Provide up-front funding to support CCHs and CBOs	• **Rhode Island**: Intends to use $3.5 million of its 1115-waiver approved "Health System Transformation Project" resources for an SDOH Investment Strategy to build capacity among the state's Medicaid Accountable Entities (Medicaid accountable care organizations) to collaborate with CBOs to address health-related social needs. • **California Health Care Foundation (CHCF)**: Launched a project to enhance the ability of Medi-Cal plans and partners to use CHWs to advance equity. The project released a resource center and resource guide based on best practices. The foundation also published on the role of CBOs in CalAIM.

Strategy	Examples/Resources
2. Support training and technical assistance (TA) to CCHs, their CBO network and partnering health care organizations	• **California**: Through its Providing Access and Transforming Health (PATH) Supports initiative, California will be launching a TA marketplace as well as convene regional collaborative planning efforts and provide funding to support capacity and infrastructure. Additionally, the Incentive Payment Program (IPP) will support capacity building for Enhanced Care Management and Community Supports. • **Massachusetts**: Under its 1115 waiver Delivery System Reform Incentive Payment (DSRIP) program, MassHealth provided technical assistance to ACOs, Community Partners and Community Service Agencies (a specific group of community behavioral health providers in Massachusetts) to support workforce and infrastructure through the Massachusetts Technical Assistance Marketplace (TA Marketplace, a website designed for participating entities to access trainings and apply for technical assistance support). The website includes both off-the-shelf trainings and a catalog of vendors.
Promote Operational Excellence	
1. Ensure key players have a clear understanding of each other's roles and responsibilities	• **Massachusetts**: Operates, under an 1115 waiver, the Behavioral Health (BH) and Long-Term Services and Supports (LTSS) Community Partners Program, in which community-based entities work with accountable care organizations (ACOs) and managed care organizations (MCOs) to provide care management and coordination to certain Medicaid members. To support program implementation, Massachusetts published detailed guidance for ACOs, Community Partners and Social Service Organizations on entity responsibilities, funding and payment details, and process flows.
2. Balance the need for standardization and accountability with flexibility to adapt to community needs	• **Rhode Island**: One of the projects funded under Rhode Island's SDOH Investment Strategy is the "Rhode to Equity" initiative to build clinical-community linkages by funding cross-sector teams composed of "health equity zones," Accountable Entities (Medicaid accountable care organizations) and community organizations. The state set various programs standards, but permits each team to determine regional priorities and emphasizes focus on community needs.
3. Support the development of the IT and data exchange infrastructure needed for service referrals, payment, program monitoring, evaluation and oversight	• **Arizona**: As part of its Whole Person Care Initiative (WPCI), partnered with the state's health information exchange (HIE), Contexture and 2-1-1 Arizona to implement CommunityCares, the statewide SDOH Closed Loop Referral System. • **California**: Launched CalAIM Data Sharing Authorization Guidance to encourage data sharing among health care, community-based and public agencies that manage care under CalAIM. California is also developing a draft Universal Authorization for Release of Information form to establish a standardized data exchange process to promote patient consent management. • **New Jersey**: Appropriated state dollars to regional entities recognized as ACOs under the NJ ACO Demonstration Project (2015–2019). ACOs could use funding toward the development and maintenance of regional health information platforms. In 2020, these ACOs were replaced by legislation recognizing these entities as regional health hubs and requiring them to "establish, operate and maintain" health information platforms.

Strategy	Examples/Resources
Create Pathways to Financial Sustainability	
1. Provide adequate reimbursement for health-related services	• **California**: California Advancing and Innovating Medi-Cal (CalAIM) is California's plan to transform the Medicaid Program (Medi-Cal) to address health-related social needs. Under CalAIM, the state is transitioning its "Whole Person Care" (WPC) pilots—implemented through its prior "Medi-Cal 2020" 1115 waiver—and its previous Health Home Program into a more sustainable program embedded within the Medicaid managed care delivery system. CalAIM includes: – Enhanced Care Management: A new benefit in which a single lead care manager coordinates care and services across the physical, behavioral, dental, developmental and social services delivery systems for the highest-need enrollees; authorized under the state's 1915(b) waiver. – Community Supports: New statewide services that are cost-effective alternatives to traditional services or settings—also known as "in lieu of services" (ILOS)—designed to address the health-related non-clinical social needs of Medi-Cal members. As ILOS, these services count toward plans' requirements to spend the vast majority of their funding on improving health (rather than administrative expenses). Most Community Supports are implemented under the managed care ILOS authority, though some are authorized through a combination of the state's 1115 and 1915(b) waivers. All Medi-Cal managed care plans are encouraged to offer as many of the 14 pre-approved Community Supports as possible and are required to partner with provider organizations (including CBOs) to provide them. • **Massachusetts**: The most recently approved 1115 waiver requires ACOs and MCOs to contract directly with Community Partners (CPs), a shift from prior program policy under which the state contracted directly with CPs, to help ready CBOs and ACOs/MCOs for sustainability beyond the demonstration period.

Strategy	Examples/Resources
2. Collaborate with other federal, state, local and non-profit/private organizations to align resources	• **Louisiana**: The Permanent Supportive Housing (PSH) Program combines permanent, subsidized rental housing with flexible, individualized housing and tenancy supports for individuals who have significant long-term disability, are receiving Medicaid or Ryan White services and meet income requirements. The program was borne from collaboration between the Louisiana Department of Health (Medicaid agency), Office of Aging & Adult Services, the Louisiana Office of Community Development, the Louisiana Department of Children & Family Services, the Louisiana Housing Corporation/Housing Authority, and advocates for people with disabilities and experiencing homelessness. Funding for the program is braided across various sources, including: Low Income Housing Tax Credit Program (LIHTCP), rental subsidies (such as Continuum of Care (Shelter Plus Care), Section 811 Project Rental Assistance Program), 1915(c) Home and Community-Based Services waiver, Medicaid State Plan, Ryan White, Cooperative Agreement to Benefit Homeless Individuals, Veterans Services, and Community Development Block Grant. • **Massachusetts**: Collaborated with the Department of Public Health (DPH) and the Health Policy Commission (HPC) to forge partnerships between Medicaid ACOs, CBOs and Social Service Organizations (SSOs). MassHealth oversees Medicaid ACOs; DPH helped SSOs build capacity via a learning collaborative and funding; HPC created an ACO certification process and investment programs that indirectly support these partnerships. • **North Carolina**: Office of Rural Health and Medicaid agency collaborated to establish complementary programs—the North Carolina Community Health Worker COVID-19 Program and COVID-19 Support Services Program with a combination of CARES Act, state and Medicaid funding to coordinate and pay for select support services (e.g., food, financial assistance) for individuals isolating/quarantining due to COVID-19. Four hub organizations selected by the state managed the local organizations providing the support services. CHWs used an attestation form to help assess eligibility and refer people to these organizations. • **Collaborative funding models**: – CommonSpirit Community Bank: CommonSpirit Health, one of the largest nonprofit health systems in the U.S., developed the Connected Community Network (CCN) model, which features a neutral community convener that manages a network of CBOs that provide services and a referral infrastructure to connect underserved populations to community resources. Each CCN relies on a "Community Bank"—a locally controlled pool of funds financed from different sources (e.g., health providers, health care payers, government agencies and foundations) to cover shared network costs, such as convener project management and facilitation and community capacity. ▪ In San Joaquin County, California, for example, the convener, United Way of San Joaquin, received commitments from 11 funding partners, including but not limited to health systems and managed care, which have raised $200,000 annually to support a technology platform operated by Unite Us to support the community-led network of partners to collectively address the social needs of San Joaquin residents. – **CAPGI (Collaborative Approach to Public Goods Investments)**: CAPGI is a collaborative funding model in the early stages of feasibility analysis and implementation that aims to help multi-stakeholder coalitions sustain new SDOH investments using local capital and a collaborative bidding process. This model has begun being piloted to finance SDOH initiatives, such as supportive housing, medically tailored meals and post-natal home visiting, in 11 communities across the country.

Strategy	Examples/Resources
3. Support evaluation frameworks and outcome measurements to identify long-term value	**Innovative state efforts to support evaluation** • **New Jersey**: The New Jersey Integrated Population Health Data Project (iPHD) is a collaboration among New Jersey Department of Health, Department of Human Services (including Medicaid), other state departments/agencies, universities and members of the public that facilitates access to integrated data from different governmental entities to promote research that may be used to support research design, implementation and evaluation of population health programs. Current research priorities SDOH's and whole person care, improving maternal and child health outcomes, addressing the opioid epidemic, and responding to COVID-19 and other public health emergencies. **Social Interventions Research & Evaluation Network (SIREN)** • Housed at the Center for Health and Community and the University of California, San Francisco and supported by Kaiser Permanente and the Robert Wood John Foundation, SIREN is a network that seeks to accelerate high-quality research through innovation grants; collect, summarize and disseminate research and findings; and increase research capacity by providing consulting services to safety net and mission-aligned health systems. Social Interventions Research & Evaluation Network (SIREN) Evidence and Resource Library includes peer reviewed publications and other types of resources building the evidence base for medical and social integration. **State Medicaid agency evaluation examples**: • M**assachusetts**: Evaluation design for investments in "Community Partners" and "Flexible Services." – Midpoint assessment • **California**: Evaluation design for "Whole Person Care Pilots." – Interim Evaluation report **Other relevant evaluation resources**: • CDC Evaluation Documents, Workbooks and Tools • Accountable Health Communities (AHC) Model Evaluation First Evaluation Report • Blue Sky Consulting Group, "Accountable Communities for Health: An Evaluation Framework and Users' Guide" for the California Health and Human Services Agency and Department of Public Health • FSG Guide to Evaluating Collective Impact

Strategy	Examples/Resources
Look Upstream	
1. Support community revitalization	• **General Publication**: Healthy People 2030 recognizes civic engagement as an important SDOH and critical to achieving health equity. • **Community Re-investments**: The following states have directed or encouraged MCOs to reinvest a portion of revenue or profits into the communities they serve: – **Arizona** requires MCOs to invest six percent of annual profit into community-based initiatives (section D of managed care contract), submit a plan detailing its anticipated activities (including expected beneficiaries and how they will benefit), and report activities to the state in compliance with the Community Reinvestment Policy, the Community Reinvestment Plan Template (Attachment A) and the Community Reinvestment Report (Attachment B). – **Nevada** is proposing in its re-procurement RFP to require MCOs to invest three percent of pretax profits into the community being served. MCOs are required to submit a plan to the state explaining their proposed community reinvestment activities. – **North Carolina** encourages health plan community reinvestment by allowing plans that fail to meet the medical loss ratio (MLR) standard to invest dollars they otherwise would need to rebate to the state in activities to address SDOH. Health plans that proactively reinvest in the community served also may be rewarded with a one percent bump in their auto-assignment algorithm. – **Oregon** requires CCOs to reinvest a portion of the plan's previous year's net income into Oregon's SDOH and Equity spending program (known as the "Supporting Health for All through Reinvestment (SHARE) Initiative") and into local community initiatives (e.g., reducing health disparities, addressing homelessness, providing parenting classes). – **Tennessee** is proposing in its re-procurement RFP to require MCOs to commit community reinvestment spending as part of their application response, which will be followed by an annual MCO's minimum community investment requirement thereafter. RFP respondents will be scored on their level of community investment commitment. • **Oregon**: 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.
2. Recognize racism as a driver of health	• **Oregon**: The Oregon Health Authority Maternal and Child Health (MCH) Section has articulated its commitment for a vision for racial equity and published a policy on racial equity alongside. The MCH website has several tools to promote racial equity, including a racial equity assessment and action plan and resources related to: – Implicit bias (Implicit Bias Fact Sheet; Implicit Bias Review; Conscious and Unconscious Bias in Health Care Course) – Health literacy (Create a Health Literacy Plan; CDC Health Literacy Website; Maximus Center for Health Literacy) – Cultural and linguistic services (CLAS) standards (15 national CLAS standards) • **CDC**: Explicitly acknowledges racism as a driver of health and has launched several nationwide public health efforts to combat racism, including providing health equity funding for health departments, funding community health workers, promoting science and research, addressing SDOH, promoting racial and ethnic approaches to community health, and infrastructure and pipeline efforts to diversify the workforce.

Strategy	Examples/Resources
3. Build and support the workforce	• **General**: Several states have taken advantage of HRSA workforce programs aimed at developing the pipeline and enhancing the diversity of health professionals, supporting student loan repayment and scholarships, and promoting resilience. • **Massachusetts**: Leveraged DSRIP dollars towards student loan repayment to recruit the primary care and behavioral health workforce serving in community-based settings, including special funding designated for those working at Community Mental Health Centers. The Commonwealth also invested in the creation of Medicaid ACOs, with flexibility to hire CHWs and other paraprofessionals as part of their efforts to improve outcomes and decrease total cost of care.

[1] County Health Ranking Roadmaps. County Health Ranking Models.

[2] Ferguson, M., & Newman, N. (2021, October 25). The Role of Medicaid in Addressing Social Drivers of Health: MCO Community Investment Requirements. *Manatt Health.*

[3] Miller, E., Nath, T., & Line L. (2017, June). Working Together Toward Better Health Outcomes. *Partnership for Healthy Outcomes (A collaborative of the Nonprofit Finance Fund, Center for Health Care Strategies and Alliance for Strong Families and Communities).*

[4] Center for Health Care Strategies and Nonprofit Finance Fund. (2018, August). Advancing Partnerships between Health Care and Community-Based Organization to Address Social Determinants of Health: Executive Summary.

[5] National Academies of Sciences, Engineering, and Medicine.(2019, September). Integrating Social Needs Care into the Delivery of Health Care to Improve the Nation's Health.

[6] County Health Ranking Roadmaps. County Health Ranking Models.

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