FUNDING WHOLE-PERSON HEALTH

Opportunities to Make Essential Needs Initiatives More Sustainable

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Opportunities to Make Essential Needs Initiatives More Sustainable

In recent years, a broad spectrum of medical practices have launched initiatives to help address patients' essential resource needs — like food and housing — as a standard part of care delivery. Many organizations support these programs through a combination of internal operational funds, grant funding and philanthropy. But comparatively few have uncovered clear pathways to make these initiatives financially sustainable in the long term.

This guide and its supporting Essential Needs Funding Table are intended to help healthcare practices identify the range of potential funding opportunities available — and understand how these initiatives may or may not align with their desired care delivery model. Here we offer a high-level summary of primary care payment reform efforts and funding opportunities that can support providers in developing value-based, community-centered care models. **These reform initiatives and funding opportunities fall largely into four primary categories:**

MEDICAID OPPORTUNITIES

- Medicaid Accountable Care Organizations (ACO)
- Delivery System Reform Incentive Payment (DSRIP) Program/1115 Waivers
- Medicaid Managed Care (MCO)
- Health Homes Program
- Medicaid Targeted Case Management (TCM)

MEDICARE OPPORTUNITIES

- Medicare Next Generation Accountable Care Organizations (ACOs)
- Medicare Chronic Care Management (CCM)
- Medicare Advantage Plan (MA)

MULTI-PAYER OPPORTUNITIES

- Comprehensive Primary Care + 1&2 (CPC+)
- Accountable Health Communities (AHC)

PRACTICE-BASED OPPORTUNITIES

- Section 330 Enabling Services
- Patient-Centered Medical Home (PCMH)
- Community Benefit

This guide breaks each category down further into key components and real-life examples to better enable providers to identify payment opportunities that align with their current practice structure, care model, target population and overall social determinants of health (SDoH) activities. We also offer additional resources to dive deeper into each of the four featured payment initiatives and models.

Have questions? Need additional information? Don't hesitate to reach out to us at network@healthleadsusa.org — or visit our full suite of resources at healthleadsusa.org/network.

GLOSSARY / ICON KEY

For ease of navigation, this guide uses the following icons to visually represent key components of each initiative or funding opportunity.

Eligible Organizations	Target Population	Payment Structure	SDoH Activities
Healthcare Provider: Licensed primary care clinicians (internal medicine, family medicine or pediatrics). Can be standalone practices or attached to a health system.	**High Risk, High Need:** Patient populations that are considered high utilizers of healthcare services, have poorly managed chronic conditions, or who may be at higher risk for morbidity and mortality due to their social or environmental circumstances.	**Fee-for-Service (FFS):** A payment is received for each service provided.	**Essential Needs Screening:** Intentional identification and documentation of unmet essential needs — like food, housing and transportation — among patients served.
Behavioral Health Provider: Licensed behavioral health providers at standalone practices or attached to a health system.	**Rising Risk:** Patient populations that do not fall into the "high risk, high need" category — but who may have medical, behavioral or social factors that, if left unaddressed, could negatively affect their health.	**FFS with Shared Savings/Risk:** Payment is received per service provided, but at the end of the contract year, total costs are compared to a negotiated benchmark for the population served. If the total cost is less than the benchmark, the provider keeps a percentage of the savings. If the total cost is over, the provider may owe the health plan a percentage of the loss.	**Resource Referral:** Written information provided to patients on how to access specific community resources that address unmet essential needs.
Community-based Organizations: Providers of social service supports to local communities.		**Global Budget:** The healthcare delivery organization is paid a lump sum to provide services and manage the care of a defined patient population.	**Resource Navigation:** Case management support provided to patients with unmet essential needs to enable them to access and receive resources to support their health.

Eligible Organizations	Target Population	Payment Structure	SDoH Activities
Health Plans: Third-party payer for healthcare services.		**Grant Award:** One-time payment of funds for a specific service or care delivery transformation effort.	**Community Partnerships:** Formal relationships with community-based organizations to improve patient access to local resources.
		PMPM Capitation: A set 'per-member, per-month' payment is made to the provider or healthcare delivery organization for each attributed patient. Monthly rates are negotiated with the health plan and may vary based on the complexity of the populations served.	**Community Health Needs Assessment:** Collection of data to understand the health outcomes, risk factors and care/resource gaps within a community.
		Monthly or Quarterly Capitation: Additional lump sum paid from the health plan to the healthcare delivery organization or provider to cover the costs of non-billable activities that support high quality care delivery — such as care coordination, care management or resource navigation.	

Eligible Organizations	Target Population	Payment Structure	SDoH Activities
		Prospective & Retrospective Quality Adjustment: Performance-based (bonus) funds, either paid at the start or at the close of a contract year — based on the healthcare provider's performance on quality indicators.	
		FQHC Prospective Payment System: Federally Qualified Health Centers receive a single, bundled rate for each qualifying patient visit that pays for all covered services and supplies provided during the visit. This helps to cover services that are often not covered by fee-for-service Medicaid — such as case management, translation, transportation and some dental and mental health services. Rates are calculated based on the historical costs of providing comprehensive care to Medicaid patients.	

MEDICAID ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Program Overview

Payment and care delivery model designed to reduce costs and improve care coordination by holding providers financially accountable for the health of the patient population they serve. This accountability is achieved through three key activities:

1. Implementing a value-based payment structure
2. Measuring quality improvement
3. Collecting and analyzing data

Care Model

Strong focus on coordinating and navigating patients to services across the continuum of care. Use of systems to facilitate communication and data sharing between medical care, behavioral health and social service providers is strongly encouraged.

Eligible Organizations


Healthcare Provider


Behavioral Health Provider


Community-based Organizations

In states with Medicaid ACO programs, health care delivery organizations that participate in the Medicaid program and managed care organizations are eligible. Behavioral health, substance use and long-term care providers funded through state Medicaid — as well as community service providers — may also be included in contracts.

Target Population


High Risk, High Need


Rising Risk

Medicaid beneficiaries

Payment Structure


FFS with Shared Savings/Risk


Global Budget

States commonly use one of two payment models:

1. Shared Savings Arrangement: ACO providers can capture a share of the savings if care delivered to their attributed population is less costly than an established benchmark (often based on the prior year's costs). Arrangements may transition over time to include "downside risk" where providers must pay a portion of costs if they exceed established cost benchmarks.
2. Global Budget Model: ACOs receive a capitated per-patient payment to provide services and accept full financial risk for the health of their patient population.

SDoH Activities


Essential Needs Screening


Resource Referral


Community Partnerships

Specific SDoH activities vary by state, but can include:

- Partnership requirements
- Care management requirements
- Scope of services
- Quality metrics
- Financial incentives

States Where Specific Payment or Delivery System Reforms Apply

Colorado, Connecticut, Iowa, Maine, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

Provider Implications

Opportunity to pool resources with other providers and establish systems to improve coordination of patient care — and support services and manage care at the population level for Medicaid beneficiaries.

Additional information and state-specific details available in the Center for Health Care Strategies (CHCS) Medicaid ACO Resource Center: http://bit.ly/HLchcs218

DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM & 1115 WAIVERS

Program Overview

State Medicaid demonstration programs that waive certain federal Medicaid requirements to allow for movement toward value-based payment structures and more integrated, coordinated care.

Care Model

Varies by state

Eligible Organizations

Healthcare Provider · Behavioral Health Provider · Community-based Organizations · Health Plans

Healthcare and other service providers. Can include special partnerships of healthcare and social service organizations, including Medicaid Managed Care Organizations.

Target Population

High Risk, High Need · Rising Risk

Medicaid beneficiaries

Payment Structure

Grant Award

Varies across state waivers, but all must maintain budget neutrality.

SDoH Activities

Community Partnerships

- Population health-focused projects and metrics
- Flexible services funding
- Engaging community-based organizations

States Where Specific Payment or Delivery System Reforms Apply

Alaska, Alabama, Arkansas, California, Colorado, Florida, Indiana, Iowa, Illinois, Kansas, Kentucky, Louisiana, Maine, Michigan, Minnesota, Mississippi, Montana, New Hampshire, New Mexico, North Carolina, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Texas, Vermont, Washington, West Virginia, Wisconsin, Wyoming

Provider Implications

DSRIP projects provide extra funding/resources for a finite amount of time to support payment and care delivery transformation. This may include funding to support establishment of partnerships between healthcare and social service providers.

Additional information and state-specific details available from:

- Kaiser Family Foundation - Overview of DSRIP Waivers: http://bit.ly/HLkff92914
- National Academy for State Health Policy - Using DSRIP to Improve Population Health: http://bit.ly/HLnashp5117
- Center for Health Care Strategies - Addressing SDoH via Medicaid Managed Care Contracts & Section 1115 Demos: http://bit.ly/HLchcs1218
- Center for Health Care Services - DSRIP State Program Tracking: http://bit.ly/HLchcs12516

MEDICAID MANAGED CARE ORGANIZATIONS (MCOS)

Program Overview

Medicaid health benefits and additional services are managed for beneficiaries by Managed Care Organizations (MCOs) that contract with state Medicaid agencies. This is a common strategy to encourage the coordination of care and control healthcare costs.

Care Model

Managed care contracts often emphasize the importance of a medical home for Medicaid beneficiaries. There is growing support for providers to address SDoH as part of care delivery, including funding for Community Health Workers (CHWs). Some states adopt a primary care case management model, where a primary care provider must approve and monitor use of medical services for beneficiaries in their care.

Eligible Organizations

Healthcare Provider · Behavioral Health Provider

Healthcare and other service providers that contract with Medicaid MCOs.

Target Population

High Risk, High Need · Rising Risk

Medicaid beneficiaries

Payment Structure

PMPM Capitation · FFS with Shared Savings/Risk

MCOs generally receive a per-member-per-month (PMPM) capitation rate, often with some portion contingent on quality performance via incentive and withhold arrangements (e.g. Michigan's Pay for Performance program, which includes items related to SDoH). MCO payment to providers for services can include a fee-for-service structure or varying degrees of value-based payment arrangements.

SDoH Activities

Essential Needs Screening · Resource Referral · Community Partnerships · Community Health Needs Assessment

Common SDoH activities that can be included in MCO contracts:

- Develop relationships and contract with local community organizations to implement social determinant initiatives
- Collaborate on community health needs assessments
- Develop or access a community resource directory
- Evaluate members' health-related social needs and refer individuals to appropriate community services
- Utilize data to address health disparities
- Share information (e.g., health records) with community organizations

States Where Specific Payment or Delivery System Reforms Apply

Arizona, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming

Provider Implications

As states move to incorporate activities to address SDoH in MCO contracts, providers contracting with MCOs may be expected to incorporate these activities into their model of care (e.g. screening patients for unmet essential needs).

Additional information and state-specific details available from:

- Medicaid and CHIP Payment and Access Commission - Managed Care Overview: http://bit.ly/HLmacpac7118
- Kaiser Family Foundation - Medicaid MCOs and Access to Care: http://bit.ly/HLkff3518
- Kaiser Family Foundation - Medicaid Enrollment in Managed Care by Plan Type: http://bit.ly/HLkff7116
- CMS State Medicaid Profiles & Data Collections: http://bit.ly/HLcms418
- National Academy for State Health Policy - How States Address SDoH in Medicaid Contracts & Guidance Documents: http://bit.ly/HLnashp81318
- Health Leads & CHCS - Measuring SDoH & State Lessons from Medicaid: http://bit.ly/HLchcs22219

HEALTH HOMES PROGRAM

Program Overview

Medicaid State Plan option that allows states to provide care coordination / care management services to beneficiaries with eligible chronic conditions.

Care Model

CMS allows significant flexibility in health home design — explicitly focused on team-based, whole-person care that integrates medical care, behavioral healthcare and social service needs. Care managers serve as the main point of contact responsible for coordination of services throughout the care continuum.

Eligible Organizations

Determined by State Medicaid, but may include primary care practices, community mental health organizations, addiction treatment providers, FQHCs and other safety-net providers. Often eligible organizations contract with community-based organizations to support the provision of services.

Target Population

Medicaid beneficiaries with:

- Two or more chronic conditions; or
- One chronic condition and are at risk for a second; or
- One serious and persistent mental health condition

Payment Structure

Payment is based on the delivery of Health Home core services:

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care / follow up
- Patient & family support
- Referral to community and social support services

SDoH Activities

- Screening for unmet essential needs
- Providing referrals to and navigation support for community-based services
- Collaboration with relevant community-based service providers on individual care plans

States Where Specific Payment or Delivery System Reforms Apply

Alabama, Connecticut, District of Columbia, Iowa, Maine, Maryland, Michigan, Minnesota, Missouri, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Rhode Island, South Dakota, Tennessee, Vermont, Washington, West Virginia, Wisconsin

Provider Implications

Health Homes can provide an additional funding stream to support staff hiring — and acquiring appropriate technology — to provide complex care management services to high risk, high need Medicaid beneficiaries with chronic conditions.

Additional information and state-specific details available from:

- CMS Health Homes Overview: http://bit.ly/HLcms1215
- CMS Health Homes Information Resource Center: http://bit.ly/HLcms12118
- CMS 2018 Quality Measures for Medicaid Health Home Programs http://bit.ly/HLcms2018

MEDICAID TARGETED CARE MANAGEMENT (TCM)

Program Overview

Case management support, targeted to specific groups of Medicaid beneficiaries to assist them in obtaining medical and other services necessary for treatment.

Care Model

Medicaid beneficiaries are assigned to a single case manager. Case manager qualifications vary by state, but they cannot provide direct services. They do, however, provide assessments to determine beneficiaries' needs, develop care plans, provide referral and related activities — and monitor and follow-up with their assigned patients. Beneficiaries receiving case management services must have treatment plans that are monitored by their case manager.

Eligible Organizations


Healthcare Provider


Behavioral Health Provider


Community-based Organizations

Restricted to case management providers who are qualified to participate in State Medicaid. States may limit provider participation to specific individuals or entities by setting forth qualifying criteria that ensure participating case managers are able to connect individuals to needed services.

Target Population


High Risk, High Need


Rising Risk

Targeted beneficiary groups can be defined by disease or medical condition — or by geographic regions, such as a county or a city within a state. Beneficiaries in institutional care are excluded.

Payment Structure


Fee-for-Service (FFS)

Medicaid TCM is an optional service which must be approved by CMS through a state plan amendment. Covered services include: patient assessments, development of care plans, referral and related activities, and monitoring and follow-up with beneficiaries. States often use fee-for-service payment based on time intervals of 15 minutes or less.

SDoH Activities


Essential Needs Screening


Resource Navigation

Case managers help beneficiaries access social services that support their treatment plans. However, these activities are only reimbursable if the beneficiary does not currently receive support for a given resource elsewhere. For example, housing navigation support would not be funded if a beneficiary already qualifies for assistance through another housing program.

States Where Specific Payment or Delivery System Reforms Apply

Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Montana,New Hampshire, New Jersey, New Mexico, New York, Nevada, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming

Provider Implications

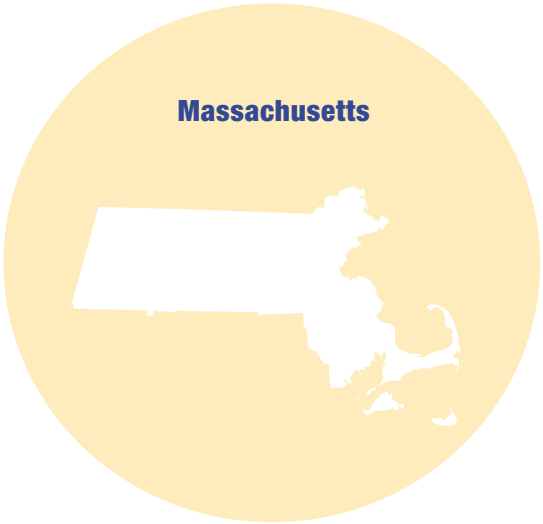
Medicaid TCM can provide an additional revenue stream to support eligible high risk, high need patients to meet their health goals.

Additional information and state-specific details available from:

- Kaiser Family Foundation - Medicaid Benefits - Targeted Case Management: http://bit.ly/HLkff18
- Congressional Research Service - Medicaid Targeted Case Management Summary: http://bit.ly/HLcrs32708

PROVIDER EXAMPLES

Massachusetts

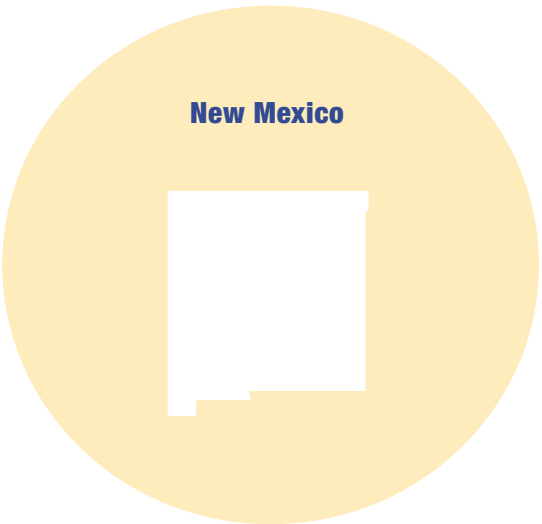


A Federally Qualified Health Center (FQHC) in Boston, Massachusetts uses a combination of funding sources to support its efforts to screen patients served for unmet essential needs and provide referrals and navigation services:

- Two Resource Specialists (1.75 FTE) in Adult Medicine are covered through the operational budget of the health center, which includes funding for Enabling Services.
- Three FTEs in Pediatrics including the Program Manager (who supervises volunteers) and two Community Health Workers (CHWs), are covered through grants from a local family foundation for behavioral health integration.
- In Obstetrics, a CHW is grant-funded through a Public Health Department grant.
- Funding for an additional CHW in Adult Medicine has been made possible from participation in their local Medicaid ACO.

The FQHC is also recognized as a Level 3 NCQA Patient-Centered Medical Home . Data collected through their program supports maintaining this recognition, as well as participation in Uniform Data System (UDS) reporting requirements.

New Mexico



A New Mexico-based FQHC negotiated per-member, per-month (PMPM) rates with a local Managed Care Organization (MCO). This funding stream specifically provides additional support for care of high risk, high need patients.

The FQHC maintained a front-line team of CHWs, and was able to demonstrate a 4:1 return on investment — largely driven by reductions in ED visits and pharmaceutical costs. This helped the FQHC negotiate a tiered PMPM payment for care management and navigation services, covering both high- and rising-risk patients.

The resulting system incentivized efforts to see patients outside of their usual medical visits and provided a dedicated funding stream for the department that housed the CHW team. This put CHW-led initiatives on more of an equal footing with other medical services in the health center.

MEDICARE NEXT GENERATION ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Program Overview

The Next Generation Accountable Care Organization (ACO) model is an initiative specifically for ACOs that are experienced in coordinating care for populations of patients. Provider groups assume higher levels of financial risk and reward than currently available under Medicare's current Pioneer Model and Shared Savings Program (MSSP).

Care Model

Payment mechanisms help to enable graduation from fee-for-service (FFS) models to All-Inclusive Population Based Payments (AIPBP). The model has several "benefit enhancement" tools to help ACOs improve engagement with beneficiaries, such as:

- Greater access to post-discharge home visits, skilled nursing facilities and telehealth services
- Opportunities for reward payments for annual wellness visits;
- A process for beneficiaries to confirm their care relationship with ACO providers
- Greater collaboration between CMS and ACOs to improve communication with beneficiaries

Eligible Organizations

ACOs with strong past performance in the Medicare Shared Savings Program are selected through a competitive application process to CMS.

Target Population

Medicare fee-for-service beneficiaries

Payment Structure

AIPBP is a capitation-based payment model that includes financial arrangements with higher levels of risk and reward than current Medicare ACO initiatives, using new benchmarking methods. ACOs have choice of two risk arrangements that determine the portion of the savings or losses that accrue.

SDoH Activities

This program does not tie specific funding to addressing SDoH. Some ACOs are starting to integrate patient-level data on essential needs with health data and experimenting with investments in upstream strategies that address SDoH.

States Where Specific Payment or Delivery System Reforms Apply

Arizona, California, Delaware, Florida, Iowa, Idaho, Indiana, Louisiana, Massachusetts, Michigan,Minnesota, Missouri, North Carolina, New Hampshire, New Jersey, New York, Rhode Island, Texas, Utah, Virginia, Vermont, Washington, Wisconsin

Provider Implications

As providers improve the efficiency of clinical processes and reduce waste, ACOs are finding that a focus on addressing unmet essential needs is necessary to sustain cost savings and effectively manage population health. This is particularly true among patients who are considered high risk, high need.

Additional information and state-specific details available from:

- Center for Medicare & Medicaid Innovation - Next Generation ACO Model Overview and State Models: http://bit.ly/HLcmmi12118
- AJMC - Tying Social Determinants of ACO Patients With High-Need, High-Cost Care: http://bit.ly/HLajmc10518

MEDICARE CHRONIC CARE MANAGEMENT (CCM)

Program Overview

Chronic Care Management (CCM) service codes provide payment for care coordination and care management for patients' chronic conditions within the Medicare Fee-For-Service (FFS) program.

Care Model

CCM services may include the following:

- Structured recording of patient health information
- Comprehensive care plans
- Providing 24/7 access to physicians — or other qualified healthcare professionals or clinical staff
- Comprehensive care management
- Transitional care management

Eligible Organizations

Practitioners with Medicare contracts can bill for services provided by:

- Physicians
- Certified Nurse Midwives
- Clinical Nurse Specialists
- Nurse Practitioners
- Physician Assistants

Target Population

Patients with two or more chronic conditions that place them at significant risk of death, acute exacerbation/ decompensation or functional decline.

Payment Structure

Reimbursement for CCM is broken down into two categories: Standard CCM and Complex CCM. Complexity is determined by the amount of clinical staff time, care planning and intricacy of the challenges addressed by the billing practitioner. Payments range from approximately $43 to $141 depending on this complexity.

In addition, there are important guidelines to CCM reimbursement:

- A patient can receive either Standard CCM or Complex CCM services during a given period
- Only one practitioner can be paid for these services per month.
- Medicare will not make duplicative payments for similar services patients receive under other CMS demonstrations and initiatives (such as Comprehensive Primary Care+)

SDoH Activities

Billable activities include assessment for unmet essential needs and coordinating access to community resources to meet those needs.

States Where Specific Payment or Delivery System Reforms Apply

All 50 States

Provider Implications

CCM services provide additional support that can help Medicare beneficiaries manage their chronic conditions effectively — and reduce their overall cost of care in the process. Billing for CCM services allows providers to be paid for the time and effort invested in caring for patients with chronic conditions.

Additional information and state-specific details available from:

- American College of Physicians - What Practices Need to Do to Implement and Bill CCM Codes: http://bit.ly/HLacm2017
- American Academy of Family Physicians - Physician Payment Under Chronic Care Management (CCM): http://bit.ly/HLaafp2018

MEDICARE ADVANTAGE PLAN (MA)

Program Overview

Medicare Advantage (MA) is composed of health plans administered by private insurance companies. In 2018, CMS expanded the definition of "primary health-related covered benefits" to include care and devices that:

- Are used to prevent injury or illness
- Compensate for physical impairments
- Reduce avoidable emergency medical care
- Address psychological and/or functional effects of injury and illness

Care Model

Care management and efforts to coordinate care across providers and settings are common among MA plans. Health plans continue to experiment with strategies to address SDoH, depending on the resources available in each community.

Eligible Organizations

Health plans that administer MA plans are eligible, along with healthcare providers who contract with them.

Target Population

Medicare Advantage plan beneficiaries

Payment Structure

"Primary health-related benefits" covered under Medicare FFS are also covered under MA plans — and are included in the capitation rate established and paid for by CMS as billable services/initiatives. Supplemental benefits (primarily health-related or otherwise) are not covered in the MA plan capitation rate. Plans can cover these services through any available plan rebate dollars.

SDoH Activities

MA Quality Improvement Projects (QIP) and Chronic Care Improvement Program (CCIP) both include implementation of activities to identify and address unmet essential needs among beneficiaries. All MA plans are required to participate in QI activities as outlined by CMS.

States Where Specific Payment or Delivery System Reforms Apply

All 50 States

Provider Implications

Some MA plans with high numbers of dually-enrolled Medicaid/Medicare beneficiaries have found that addressing non-clinical needs can lead to higher MA Star Ratings. Higher performance can lead to bonus payments and rebates from CMS. How these efforts are funded varies across MA plans.

Additional information and state-specific details available from:

- HHS Research Report - Addressing SDoH Needs of Dually-Enrolled Beneficiaries in Medicare Advantage Plans: http://bit.ly/HLhhs2018
- CMS - Medicare Advantage Plans Overview: http://bit.ly/HLcms2019

PROVIDER EXAMPLES

Illinois

A large health system in Chicago, Illinois has centralized teams of ambulatory social workers, nurses and CHWs that partner with primary care and specialty care clinics to provide complex care management and address health-related social needs. Staff collaborate with clinic teams to identify and assess for needs impacting patients' health and management of chronic conditions, — and to provide care planning and care management to address needs.

Since 2015, the health system has used Chronic Care Management (CCM) to accrue some revenue for this work. Thus far, participating practices have been able to considerably offset the cost of staff allocated to their practice to provide such wrap-around care. While this has brought in revenue, it can be slow to come in — and unreliable as to exactly how much practices will be able to bill. Primary care providers enroll eligible patients in the CCM program, and social workers and other members of the interprofessional care team log minutes of services impacting chronic condition management (such as addressing gaps in care, providing psychoeducation and attending to health-related social needs).

CCM can make sense for healthcare delivery organizations with significant numbers of Medicare FFS patients and ample administrative support systems (in this organization's case, approximately 30% of patients are Medicare FFS). While the administrative burden is not insignificant, the system's use of Epic allows teams to track enrollees, edit shared care goals and log time spent on CCM services. To identify billable services, the health system uses the longitudinal plan of care and the CCM minutes tracker in Epic.

CMS does not designate specific disciplines or roles that are eligible to count work toward CCM. It is up to individual health systems to balance incident and scope of practice requirements to identify eligible contributors. Another consideration is that providers (physicians, APNs and PAs) have to be willing to take on a new initiative and proactively enroll and document correctly to capture goals they discuss with patients. This cannot just be driven by the social worker or CHW; a primary care physician or other billing provider must be meaningfully involved.

Rhode Island

In addition to running their local Accountable Health Communities (AHC) initiative, a health system in Providence, Rhode Island participates in:

- A NextGen Medicare ACO with 130,000 attributed lives
- Medicare Advantage plans
- Blue Cross Blue Shield commercial contracts
- Medicaid managed care contracts that cover 48,000 lives (50% of whom are children)

All of these payment initiatives incentivize the establishment of health system-wide processes to screen covered patients for unmet essential needs — and provide referrals or navigation support to local resources.

As these processes become more firmly rooted in the health system's overall care model, plans have also emerged to roll out these services to additional populations. The health system also works to strengthen local community partners' ability to address unmet essential needs among those they serve.

COMPREHENSIVE PRIMARY CARE PLUS 1 & 2 (CPC+)

Program Overview

Comprehensive Primary Care Plus (CPC+) is a payment and delivery reform demonstration project designed to strengthen primary care delivery, as supported by regionally based multi-payer payment reform. The program was launched in two rounds: CPC (2012-2016) and CPC+ (Tracks 1 and 2, each lasting five years, 2017-2021).

Care Model

CPC+ is a team-based care model focused on the following advanced primary care functions:

- Access and continuity
- Care management
- Comprehensiveness and coordination
- Patient and caregiver engagement
- Planned care and population health

Eligible Organizations

Healthcare providers are eligible within areas where states and MCOs have applied to the CPC+ program and were accepted by CMMI.* For these providers, the following guidelines apply:

1. Practices should have at least 150 attributed Medicare fee-for-service beneficiaries
2. Certified electronic health record technology is used
3. Sufficient revenue is generated by Medicare and CPC+ payer partners

Target Population

Depending on the participating state and payer, target populations could include Medicare FFS,Medicare Advantage and/or Medicaid beneficiaries.

Payment Structure

Track 1 continues to bill and receive payment for Medicare FFS as usual. Track 2 includes reduced Medicare FFS rate, plus capitated Comprehensive Primary Care Payment (CPCP) paid quarterly. Under both tracks, non-visit based, risk-adjusted per-member-per-month (PMPM) based care management fees are paid quarterly. Performance-based incentive payments are paid prospectively and are retrospectively reconciled based on performance across the following measurement categories:

- Patient experience
- Clinical quality
- Utilization

SDoH Activities

- Integration of health-related essential needs screening tool or question(s) that will identify social services and other resource needs among the patient population
- Development and use of a database of community-based services that is updated regularly
- Referrals to community-based services, along with follow-up for patients referred to services
- Formalized coordination of agreements to facilitate information sharing and linkages with community-based agencies and services
- Tracking and measurement of success rates across linkages to community resources

States Where Specific Payment or Delivery System Reforms Apply

Arkansas, Colorado, Hawaii, Kansas, Kentucky, Louisiana, Missouri, Michigan, Montana, Nebraska, New York, New Jersey, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee

Provider Implications

CPC+ offers more flexible payment arrangements to primary care practices, as well as more upfront payments to invest in infrastructure. Coupled with participation in learning opportunities, these initiatives are designed to ultimately better meet patient needs. Participating in CPC+ can also help practices to engage in value-based payment models and better manage population health.

Additional information and state-specific details available from:

- CMS - Comprehensive Primary Care Plus Initiative Overview: http://bit.ly/HLcmmi113018
- AAFP - CPC+ & Practice Management Resources: http://bit.ly/HLaafp2019

ACCOUNTABLE HEALTH COMMUNITIES (AHC)

Program Overview

Accountable Health Communities (AHC) are Center for Medicare & Medicaid Innovation (CMMI) demonstration projects in 31 communities. The initiative is designed to test whether systematically identifying and addressing Medicare and Medicaid beneficiaries' health-related essential needs — through screening, referral and community navigation services — will impact healthcare costs and reduce overall utilization.

Care Model

Two tracks exist at clinical delivery sites:

1. Assistance Track: Provide community service navigation to high risk beneficiaries
2. Alignment Track: Align partners to ensure that community services are available and responsive to the needs of beneficiaries

Eligible Organizations

Local, state and national organizations are eligible, provided they have the capacity to develop and maintain relationships with clinical delivery sites and community service providers. This includes community-based organizations, healthcare practices, hospitals and health systems, institutions of higher education, local government entities, tribal organizations and other non- and for-profit organizations.

Target Population

Medicaid and Medicare beneficiaries

Payment Structure

Awarded communities can receive up to $2.57 million for the Assistance Track or up to $4.51 million for the Alignment Track to cover the five-year performance period. No additional applications are being accepted at this time. Participant performance ends on April 30, 2022.

SDoH Activities

The model supports local communities to address the health-related essential needs of Medicare and Medicaid beneficiaries by bridging the gap between clinical and community-based service providers.

States Where Specific Payment or Delivery System Reforms Apply

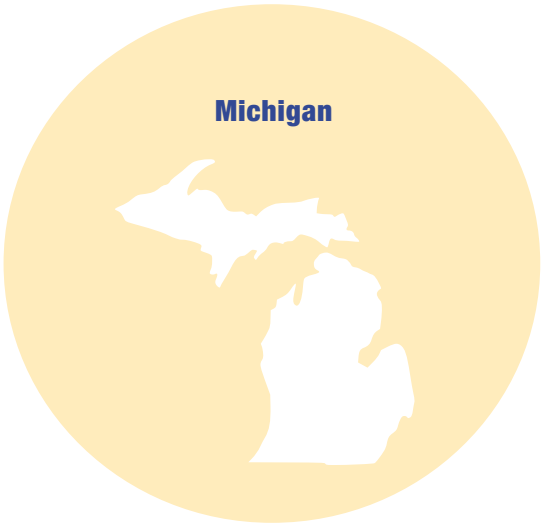
The initiative includes 31 communities, spread across the following states: Arizona, Colorado, Connecticut, Georgia, Illinois, Indiana, Kentucky, Maryland, Michigan, Minnesota, Mississippi, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Texas, Virginia, West Virginia

Provider Implications

AHC grant money can provide an additional revenue stream to screen Medicaid and Medicare patients for unmet essential needs and navigate them to related resources. Grants are intended to establish clinical-community collaboration at the local level. If the program evaluation shows positive findings, additional payers may be more likely to reimburse for future essential needs screening and resource navigation services.

Additional information and state-specific details available in CMMI's Accountable Health Communities Model Summary & Milestones: http://bit.ly/HLcmmi11719

PROVIDER EXAMPLE



Under the CMS Comprehensive Primary Care - Plus (CPC+) initiative, a medical group in Michigan cared for approximately 44,000 patients annually in their primary care practices. Patients were served by 25 practitioners and 51 non-practitioners.

The medical group's CPC+ Track 2 funding required patient screening and resource navigation services, which were provided across several primary care sites. Paper screening forms were given to patients and entered into their electronic health records by medical assistants — who also made referrals to the care management team when necessary.

The care management team utilized screening data to help identify the most prevalent need(s) in the community and guide their population health management goals. Gaps in the local resource landscape were prioritized and incorporated into the organization's five-year strategic plan, with an overall goal to reduce gaps by 30%.

SECTION 330 ENABLING SERVICES

Program Overview

Section 330 covers non-clinical services that aim to increase access to healthcare and improve overall health outcomes.

Care Model

Enabling Services help health centers become comprehensive 'healthcare homes' for the patients they serve. These services include comprehensive care management and other activities to improve patient access to non-medical, social, educational or other related services (e.g., childcare, food banks/meals, employment and education counseling, legal services, etc.).

Eligible Organizations

Providers must work within a Health Resources & Service Administration (HRSA) grantee health center.

Target Population

Medically underserved populations and/or geographic areas

Payment Structure

Primary sources of funding include:

- Bureau of Primary Health Care (BPHC) Section 330 Grants
- Medicaid reimbursements — including fee-for-service, managed care and wraparound funds
- Other grants — such as state, local and private funding

Enabling Services are also partially funded for eligible beneficiaries through Medicaid payments. Prospective Payment System (PPS) Medicaid rates in some states include a portion of the cost for these services.

SDoH Activities

Enabling Services include case management, referrals, translation/interpretation, transportation, eligibility assistance, health education, environmental health risk reduction, health literacy, outreach and legal aid support — all designed to reduce barriers to care for patients. The mix of services are customized by each health center to meet the needs of their respective communities.

States Where Specific Payment or Delivery System Reforms Apply

All 50 States

Provider Implications

For Federally Qualified Health Centers (FQHCs), Enabling Services are a source of revenue to support non-billable activities that address barriers to care among patients and communities served.

Additional information and state-specific details available in the 2010 report from NAHC's Enabling Services Accountability Project: http://bit.ly/HLnahc2010

PATIENT-CENTERED MEDICAL HOMES (PCMH)

Program Overview

Patient-Centered Medical Homes (PCMH) is a recognition program for primary care providers through various organizations/entities, including the National Committee for Quality Assurance (NCQA) and other state-based PCMH initiatives.

Care Model

PCMH is a team-based, patient-oriented model with a focus on coordinated care and continuous quality improvement.

Eligible Organizations

Practices are eligible that have one or more primary care clinicians who provide first-contact, continuous and comprehensive primary care for at least 75% of their patients.

Target Population

Targeted beneficiary groups can be defined by disease or medical condition — or by geographic regions, such as a county or a city within a state. Beneficiaries in institutional care are excluded.

Payment Structure

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) rewards clinicians who earn PCMH recognition via two payment pathways: Merit-based Incentive Payment System (MIPS) and the Advanced Payment Model (APM). Many payers offer benefits ranging from enhanced reimbursement, to preferred provider status, to complimentary coaching and practice support.

Currently, 29 public sector initiatives across 25 states require PCMH recognition as part of their medical home initiatives. State Medicaid programs like New York may offer enhanced reimbursement based on PCMH recognition level.

SDoH Activities

Among the requirements for PCMH recognition are:

- Identification of resource needs and establishment of connections to community resources
- Development of supportive partnerships with social services organizations or schools in the community
- Maintenance of a current community resource list or directory, based on identified needs
- Use of an electronic medical record to exchange patient data securely

States Where Specific Payment or Delivery System Reforms Apply

Alabama, Arkansas, Colorado, Connecticut, Florida, Georgia, Idaho, Illinois, Louisiana, Michigan, Minnesota, Missouri, Montana, Nebraska, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Vermont, Virginia, Wisconsin, Wyoming

Provider Implications

PCMH recognition is an indication of quality care delivery. Some payers will provide enhanced reimbursement rates to practices with this recognition. NCQA revises their PCMH standards every three years and have increasingly focused on addressing SDoH and integrating behavioral health services.

Additional information and state-specific details available from:

- NCQA - Patient-Centered Medical Home Overview: http://bit.ly/HLncqa2019
- PCPCC - Patient-Centered Medical Home FAQ: http://bit.ly/HLpcpcc2019

COMMUNITY BENEFIT

Program Overview

Non-profit, tax-exempt hospitals are required to provide community benefit services. These services include financial assistance to patients unable to pay for care, as well as other community-building and community health improvement efforts.

Care Model

Community benefit dollars an be used to support programs that:

- Improve access to health care services
- Enhance the health of the community
- Advance medical or health knowledge
- Relieve or reduce the burden of government or other community health efforts

Eligible Organizations

Only non-profit, tax exempt hospitals

Target Population

Community Benefit initiatives serve vulnerable populations, including those who are: medically underserved, uninsured, burdened with medical debt, elderly, poor, people of color, non-native English speakers, refugees and immigrants, gay, lesbian, bisexual, and transgender populations, or victims of domestic violence.

Payment Structure

Annual spending reports are made to the IRS for the prior year.

SDoH Activities

Non-profit, tax-exempt hospitals must conduct a Community Health Needs Assessment (CHNA) every three years. These assessments identify significant health needs in the community served, as well as an implementation strategy for addressing those needs. Community Benefit activities must address the needs identified in the CHNA.

States Where Specific Payment or Delivery System Reforms Apply

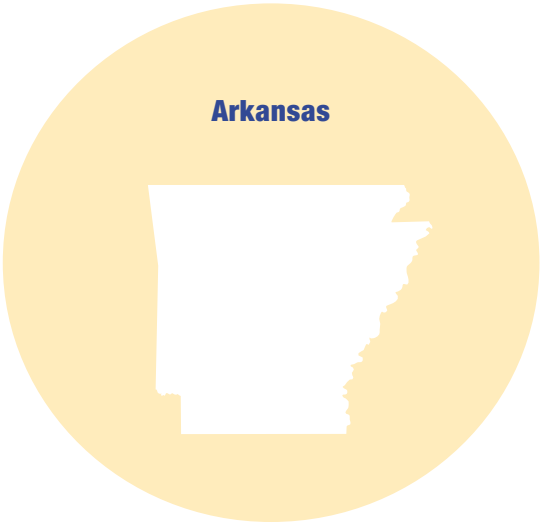
All 50 States

Provider Implications

Community Benefit funding is increasingly used to support non-clinical activities that address SDoH and are coordinated with clinical care. For example, many hospitals work to identify patients' unmet essential needs and navigate them to related resources and support in the community.

Additional information and state-specific details available from Community Benefit Connect: http://bit.ly/HLcbc2019

PROVIDER EXAMPLE



A children's hospital in Arkansas faced very limited access to value-based payment initiatives and other third-party payer contracts to support its work to identify and address unmet essential needs among underserved families.

Instead, the hospital draws on Community Benefit dollars as the primary source of funding for efforts to screen patients for unmet essential needs — and to connect families to resources to help address those needs. Additional funding for a Medical-Legal Partnership comes from the hospital's 'Innovation Fund' (operational dollars), coupled with private local grants and contracts.

ABOUT HEALTH LEADS

Health Leads is a national non-profit organization working toward a vision of health, well-being and dignity for every person in every community. For over two decades, we've worked closely with hospitals and clinics to connect people to essentials like food, housing and transportation alongside medical care.

Today, we're partnering with local organizations and communities to address systemic causes of inequity and disease — removing the barriers that keep people from identifying, accessing and choosing the resources everyone needs to be healthy.

ABOUT THE NETWORK

The Health Leads Network is a community of healthcare practitioners and caregivers who are taking action to address essential needs within our organizations. Network members work in a wide range of health system roles and settings — but share a commitment both to drive improvement initiatives on the ground, and to advance health equity in their communities.

The Network was created to bring action-oriented practitioners together to collaborate, share and learn from each other. We translate critical front-line experience into tangible tools, guidance and learning opportunities — all designed to support members in advancing the integration of essential needs into community-led health initiatives.

Learn more at healthleadsusa.org/network — or email network@healthleadsusa.org for additional information.