

Community Care Contracting: Sustainable Approaches to Financing



April 3, 2025



Q&A will take place at the end of the program

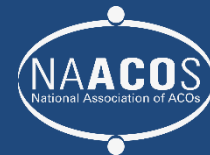
You can submit written questions using the **“Q&A” tab** (not chat) at any time during the webinar.



Webinar is being recorded

The recording and slides will be available on the [NAACOS website](#) within 48 hours.

About NAACOS



500+

ACO MEMBERS

9.5M

BENEFICIARY LIVES IN
MEMBER ACOS

76%

OF ACOS ARE NAACOS
MEMBERS

160+

PARTNER
ORGANIZATIONS



THOUGHT LEADERSHIP

NAACOS works to advance and promote coordinated, patient-centered, value-based care through research, publications, and other forms of thought leadership.



EDUCATION

NAACOS offers a variety of educational webinars, conferences, and other events to help value-based care entities stay up-to-date on the latest developments in the field and learn from experts and peers.



ADVOCACY

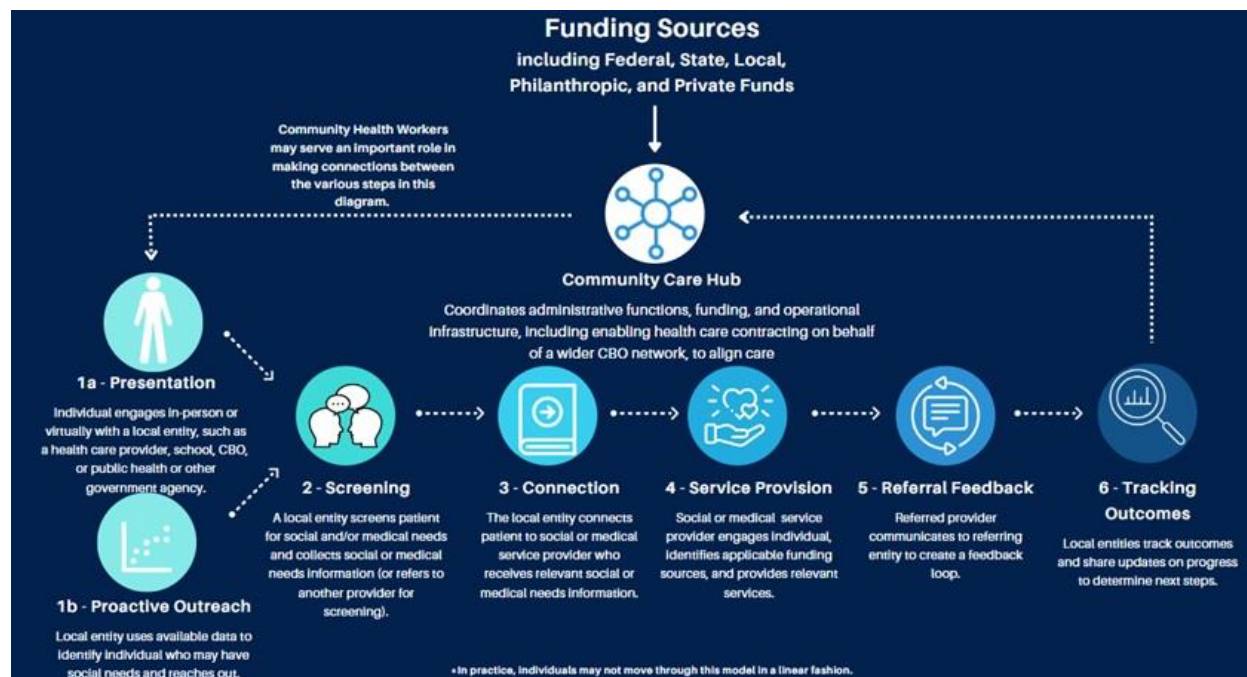
NAACOS advocates through various means, such as engaging with policymakers, participating in rulemaking, collaborating with other organizations, and communicating with the public.

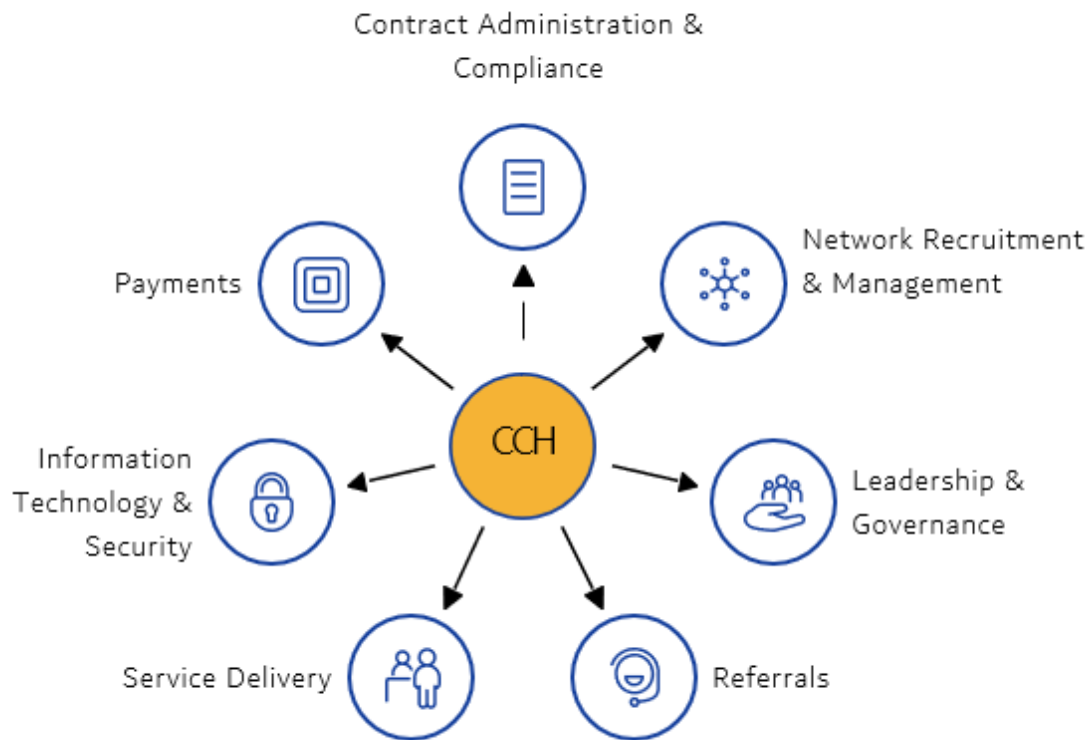
Founded in 2012, the National Association of ACOs (NAACOS) is a member-led and member-owned nonprofit helping ACOs succeed in efforts to coordinate and improve the quality of care for their patient populations.

What is a Community Care Hub?

Community Care Hubs (CCHs) are community-centered entities that:

- Develop, maintain, and support networks of CBOs providing services to address HRSNs
- Centralize administrative and operational infrastructure to help to overcome challenges
- Support establishment and sustainability of relationships between CBOs and health care orgs
- Efficiently integrate CBOs and the health-related services they offer into the health care continuum





What Does a Community Care Hub Do?



- Functions of a mature CCH (P2ASC):
 1. **Leadership and governance:** key stakeholders influence strategy and planning
 2. **Strategic business development:** assess market to identify opportunities, develop/expand contractual relationships to expand populations and services, multi-year sustainable finance strategy
 3. **Network recruitment, engagement, support:** ensure CBO network reflects local priorities/needs, onboarding process, quality control and improvement, capacity building, retention efforts
 4. **Contract administration and compliance:** evaluate, develop, execute contracts with healthcare entities, meet health sector compliance requirements, manage contract relationships
 5. **Operations:** standard workflows, fiscal management, performance evaluation, learning and development strategy
 6. **Information technology and security:** maintain policies, practices, procedures, and IT capabilities for data security and regulatory compliance, functional set of IT tools to successfully deliver services in partnership with healthcare entities

The Impact of Community Care Hubs



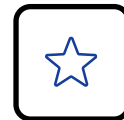
Foster Cross-Sector
Collaborations



Organized Social Care
Delivery System



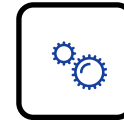
Maximizes ROI through
Social Care



Integrated Care Enhances
Quality and Star Ratings



Improved Health Outcomes



Sustainability

Speakers



Timothy P. McNeill, RN, MPH, Chief Executive and Founder, Freedmen's Health, Co-chair, Partnership to Align Social Care

Timothy P. McNeill is the founder of Freedmen's Health Consulting and Freedmen's Medicine. Freedmen's Health Consulting is a Washington, DC healthcare consulting firm specializing in implementation of innovative models of care. Freedmen's Medicine a home-based primary care practice serving older adults and persons with disability with complex care needs in the District of Columbia. Mr. McNeill also serves as the co-chair of the Partnership to Align Social Care. The Partnership to Align Social Care is a multi-sectoral group of health plans, health systems, community-based organizations and Government liaisons that work together to identify and address priority issues that are essential to a fully aligned health and social care system that incorporates the vital voice of the community. Mr. McNeill has started or expanded multiple sustainable health programs including two Medicare Shared Savings Program (MSSP) ACOs, two ACO REACH programs operating across 30 States, an IPA made up of FQHCs and independent physicians, a network of community-based free clinics, managed the operations of a network of Federally Qualified Health Centers, and established multiple regional networks to deliver Long-Term Services and Supports, contracting with MCOs, in support of State Medicaid Waiver implementation. Mr. McNeill is a Registered Nurse with a bachelor's degree from Howard University and a Master of Public Health from Eastern Virginia Medical School. Mr. McNeill is also a retired U.S. Navy Nurse Corps Officer.



David Crocker, MSHA, MBA, Director, Community Care, SARCOA/Community Care Solutions

David (Dave) Crocker joined SARCOA in February 2013 to serve as the Director of the Wiregrass Community Care Transition Program, now Director of Community Care. Dave has worked in the Alabama and Florida Panhandle health field for over 25 years with experience in the hospital, home health, hospice, and medical equipment field. Experienced with a variety of covered populations: Traditional Medicare & Medicare Replacement Plans, Medicaid, and Commercial Insurance. Focuses include population health management, chronic care management, transition care management, improving health outcomes, Social Determinants of Health impacts on health outcomes, and health coaching intervention development. He completed his BS in Business Administration at Appalachian State University. After serving in the U.S. Army as an aviator and commissioned officer in the Aviation Branch, he completed his Master of Science in Health Administration at the University of Alabama at Birmingham in 1996 along with a certificate in Gerontology. He also holds an MBA from UAB.



Chris Detter, Director, Southeast Health Statera Network

Chris has 10 years of healthcare experience. He spent 7 years as a Physical Therapist Assistant and Clinic Manager with Southeast Health outpatient Rehab Services team and the past 3+ years in his current role of Director for Southeast Health Statera Network, a Clinically Integrated Network (CIN) with over 200 physician members focused on value-based care. He has led program implementation, quality initiatives, and contracting while working with healthcare systems, skilled nursing facilities, community based organizations, Medicare Advantage plans, and Commercial Health plans. As the population health champion for Southeast Health Statera Network, Chris is passionate about achieving whole-person quality care through risk-based arrangements, partnerships, and health equity initiatives.

Partnership to Align Social Care

A National Learning
& Action Network

Advancing and socializing
Community Care Hubs (CCH)
as a preferred organized
delivery system to **enable**
sustainable, and aligned
social and health care
ecosystems providing holistic,
person-centered care.

Community Care Contracting - Sustainable Approaches to Financing

NAACOS Webinar

April 3, 2025 | 3:00 p.m. ET

June Simmons

President/CEO, Partners in Care Foundation
Partnership Co-Chair

Timothy McNeill

CEO, Freedman's Health Consulting
Partnership Co-Chair

Autumn Campbell

Director, Partnership to Align Social Care
acampbell@partnership2asc.org

National Collaborative of Multi-Sector Stakeholders



The Case for Cross-Sector Co-Design



Growing recognition about the **importance** of addressing health related social needs (**HRSN**) non-medical drivers of health.



Successful coordination and alignment of health and social care requires co-designed **delivery systems that center the community.**



Effective, sustainable **partnerships** between CBOs and health care can be **facilitated through a Community Care Hub (CCH).**



Advocate for and **operationalize** opportunities to **adopt CCH as vital partner** to organize and support a network of CBOs providing services to **address HRSNs.**

Community-Clinical Partnerships to Improve Whole-Person Care Outcomes

Timothy P. McNeill, RN, MPH

Agenda

1. Evidence Supporting Community-Clinical Partnerships
2. Pathway to Reimbursement for CHW labor
3. Case Study

Evidence





- <https://www.cms.gov/priorities/innovation/data-and-reports/2024/ahc-3rd-eval-report>
- A CMMI 5-year model (2017 – 2021) that tested whether identifying and addressing the HRSNs of Medicare and Medicaid beneficiaries impacts total health care costs and utilization.



Accountable Health Communities (AHC) Model Evaluation

Third Evaluation Report

November 2024

Submitted To:
Centers for Medicare & Medicaid Services
Center for Medicare and Medicaid Innovation
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, MD 21244-1850
Contract # HHSM-500-2014-000371
TO # 75FCMC18F0002

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Accountable Health Communities Model (2017 – 2022)

Model Overview

- The Accountable Health Community (AHC) Model tests whether connecting beneficiaries to community resources can improve health outcomes and reduce costs by screening and addressing health-related social needs (HRSNs).
- **1+ Million Medicare/Medicaid Beneficiaries** successfully screened using an evidence-based HRSN screening tool.

The AHC Model focuses on five core HRSNs:



Prevalence of HRSNs in the AHC Population (N=1+ Million)

67%



Food Insecurity: Sometimes or often worried that food would run out before money was available to buy more, or food bought did not last and money was unavailable to buy more

53%



Housing: Worried about losing housing or having no steady place to live or problems with pests, mold, lead, heat, ovens, smoke detectors, or water

44%



Transportation: Lack of reliable transportation for medical appointments, meetings, work, or getting things for daily living

36%



Utilities: Electric, gas, oil, or water company threatened to shut off services or already shut off services















5%



Interpersonal Violence: Regular occurrence of being physically hurt, insulted, threatened with harm, or screamed or cursed at by another person, including a family member

Impact on Hospital Utilization

Exhibit ES-2. Assistance Track Impacts on Expenditures and Hospital Use







 Assistance Track	Total Medicaid/Medicare expenditures 	 FFS Medicare 4% Reduction	
		 Medicaid 3% Reduction	
	Inpatient admissions 	 Medicaid 4% Reduction	
	ED visits 	 FFS Medicare 5% Reduction	
	Avoidable ED visits 	 FFS Medicare 7% Reduction	

Some Populations Had Greater Reductions in Total Cost of Care



Beneficiaries in the Assistance Track group with a diabetes diagnosis or COPD diagnosis had lower expenditures or fewer visits or stays in the first 3 years after screening for HRSNs.

Exhibit ES-4. Assistance Track Impacts on Expenditures and Use for Selected FFS Medicare Subpopulations





Subpopulation		\$ Total Expenditures	 ED Visits	 Avoidable ED Visits	 Inpatient Admissions
Overall Impact for Assistance Track		↓	↓	↓	NS
	Non-White and/or Hispanic beneficiaries	↓	↓	↓	↓
	Non-Hispanic White beneficiaries	NS	↑	NS	NS
Is there a significant difference between subpopulations?		Yes	Yes	Yes	Yes
	Beneficiaries with pulmonary disease	↓	↓	↓	NS
	Beneficiaries without pulmonary disease	NS	↑	NS	NS
Is there a significant difference between subpopulations?		Yes	Yes	Yes	No
	Beneficiaries with diabetes	↓	↓	↓	↓
	Beneficiaries without diabetes	NS	↑	NS	↑
Is there a significant difference between subpopulations?		Yes	Yes	Yes	Yes

Persons with Multiple HRSNs Had Greater Reductions in Total Cost of Care



Beneficiaries in the Assistance Track group with multiple HRSNs had lower expenditures or fewer visits or stays in the first 3 years after screening for HRSNs

Exhibit ES-5. Assistance Track Impacts on Expenditures and Use for Selected Medicaid Subpopulations

Subpopulation		\$ Total Expenditures	 ED Visits	 Avoidable ED Visits	 Inpatient Admissions
Overall Impact for Assistance Track		↓	NS	NS	↓
	Beneficiaries with multiple HRSNs	↓	↓	↓	↓
	Beneficiaries with one HRSN	↓	↑	↑	↑
Is there a significant difference between subpopulations?		No p = .72	Yes p < .01	Yes p < .01	Yes p < .01

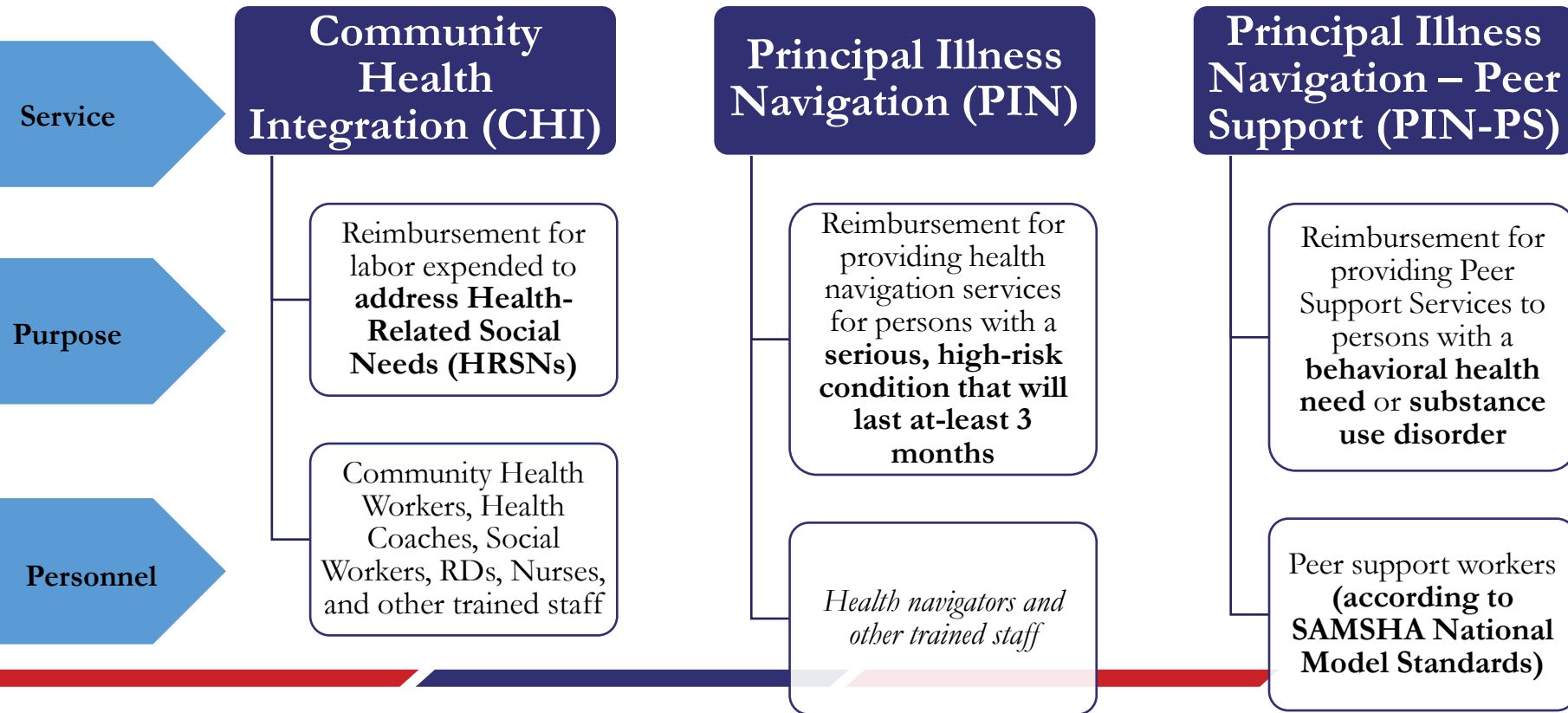
Clear Pathway to CHW Reimbursement



CMS CY2024 Physician Fee Schedule

- Landmark Final Rule creates the first of its kind pathway for reimbursement for Community Health Worker labor in the Medicare program.
- **Effective Date: January 1, 2024**
- Part B benefit which applies to persons in **Original Medicare, MA, & Special Needs Plans.**
- Applies to all Medicare Part B providers to include FQHCs & RHCs.

New HCPCS Billing Codes Supporting Whole Person Care



CHI Services List		
Person-Centered Assessment	Facilitating patient-driven goal setting	Providing tailored support
Practitioner, HCBS Coordination	Coordinating receipt of needed services	Communication with practitioners, HCBS providers, hospitals, SNFs
Coordination of care transitions	Facilitating access to community-based social services	Health education
Building patient self-advocacy skills	Health care access / health system navigation	Facilitating behavioral change
Facilitating and providing social and emotional support	Leveraging lived experience when applicable	

Role of Community-Based Organizations / CCHs

- Providers can use **auxiliary personnel** for CHI and PIN services
- Providers can contract with CBOs to provide CHI & PIN
 - CBO staff serve as auxiliary personnel
 - Contract defines the revenue paid to CBO for CHI & PIN
- Key requirements for auxiliary personnel
 - ✓ Receive general **supervision** by billing practitioner
 - ✓ Establish a **clinically integrated model of care**
 - ✓ Have **training** in all aspects of the service and, when applicable, perform services under licensure/state laws

Community Health Workers (CHWs) are potential auxiliary personnel to deliver health equity services under new final rule.

CHI HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0019	Community Health Integration Services (CHI) SDOH 60 min	\$77.96	\$47.55
G0022	Community Health Integration Services (CHI); add ea. 30 min	\$48.52	\$33.32

PIN HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0023	PIN Service, 60 minutes per month	\$77.96	\$47.55
G0024	PIN Service, add ea. 30 min	\$48.52	\$33.32

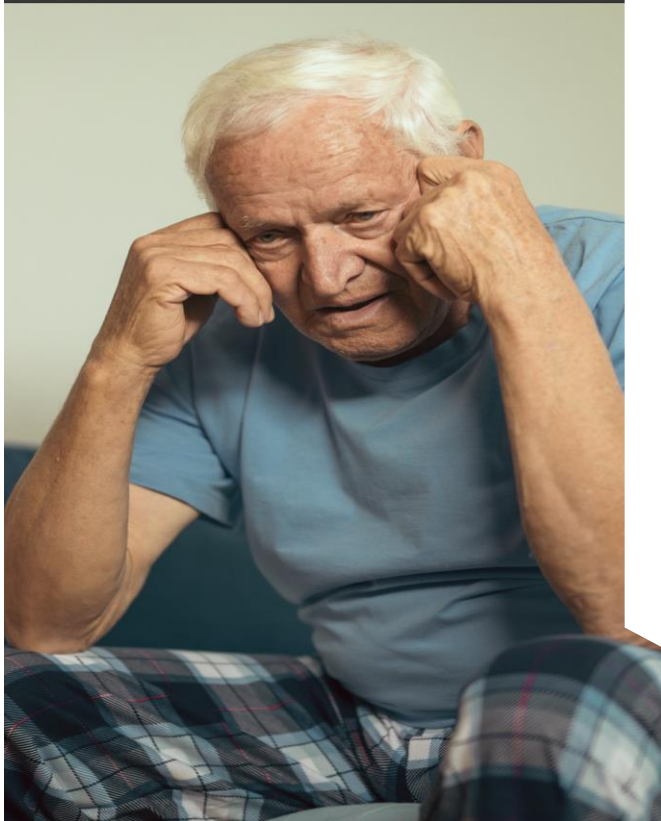
PIN-PS HCPCS	Descriptor	Non-Facility Rate	Facility Rate
G0140	PIN-Peer Support, 60 minute	\$77.96	\$47.55
G0146	PIN-PS, Peer Support, add ea. 30 min	\$48.52	\$33.32

***Rates listed are the National Rate, effective January 1, 2025**

PIN Case Study



PIN Case Study Example



- John is a 70 y/o male with a history of CHF, arthritis, and has reduced mobility.
- He lives alone in a senior apartment complex.
- His sister reports that he is frequently withdrawn and socially isolated.
- Michael's sister takes him to his doctor to because she notices that he is forgetting to take his medication on a regular basis.



PCP SDOH Risk Assessment



- PCP completes a depression screen and alcohol use screen.
- PCP completes a cognitive functioning assessment.
- Diagnosis:
 - Signs of Vascular Dementia per radiology imaging
 - CHF
 - Arthritis
 - Clinical depression



PCP Treatment Plan



- Principal Illness Navigation to address worsening depression and mild-moderate dementia.
- Deploy an evidence-based intervention to address worsening clinical depression.
- Navigation services for dementia (PIN).
 - Caregiver Training Services (CPT 97550)
- Referral made to Healthy IDEAS program.
 - Evidence-based intervention for depression and social isolation in older adults.
 - <https://healthyideasprograms.org>
- Goal:
 - Achieve remission from depression within 12 months.



PCP Orders PIN Services



- **Community Health Worker Interventions**
- Implements Healthy IDEAS program and documents PHQ-9 results based on weekly/monthly interventions.
- Deploys a short-term focused intervention to support better management of depression symptoms.
- Encourages engagement in meaningful activities.
- Supports improved disease self-management skills and medication adherence.

PIN Intervention: HEALTHY IDEAS

- Step 1: Screen and assess clients for depressive symptoms (PHQ-9).
- Step 2: Educate clients about treatment options and self-management.
- Step 3: Refer and link clients to primary/mental health care.
- Step 4: Engage clients in Behavioral Activation, an approach to depression management that helps clients combat the inactivity commonly associated with depression.
- Step 5: Reassess client progress (PHQ-9).

CHW Participates in Care Team Meetings



- CHW provides a summary of tailored support provided at weekly team meetings.
 - Baseline PHQ-9.
 - Self-Management education provided.
 - Monitor medication adherence.
 - Track CHF symptoms and report exacerbations of disease.
 - Behavioral Health activation plan.
 - Repeat PHQ-9 scores to show progression of depression symptoms.

Clinical Outcomes



- Baseline PHQ-9
- Repeat PHQ-9 score documenting remission from depression.
- Improved medication adherence based on Part D claim monitoring.
- Improved disease self-management skills.
- Utilization monitoring.
 - ED visits
 - Admissions
 - Readmissions

Thank you!

Tim McNeill, RN, MPH

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Dave Crocker
MSHA, MBA
Director
Community Care



Christopher Detter
Director
Southeast Health
Statera Health

Intro To SARCOA & Community Care Solutions



- **Improving Care Management and Coordination thru healthcare integration**
- **Facilitating Contracting with Healthcare Community**

Part C Health Plan w
PMPM w performance
metrics

Veteran Directed Care
Case Management
Contract - FL & AL

TCM CCM Provider
Contract

Previous Contracts:

EMS Post Call
Assessment

CHF Pt Tracking



SOUTHEAST HEALTH STATERA NETWORK

A Physician Hospital Organization established in 2015 in Dothan, AL by a group of physicians, Southeast Health, and the Houston County Health Care Authority. As a Clinically Integrated Network and Accountable Care Organization our collaborative works to balance quality and cost to create healthcare value.

- 11 Independent Physician Practices
- Southeast Health – 420 Bed Hospital, 6 Primary Care clinics, and multiple Specialty Groups
- 200+ Provider members
- 18,000+ covered lives across all contracts (ACO & MA)



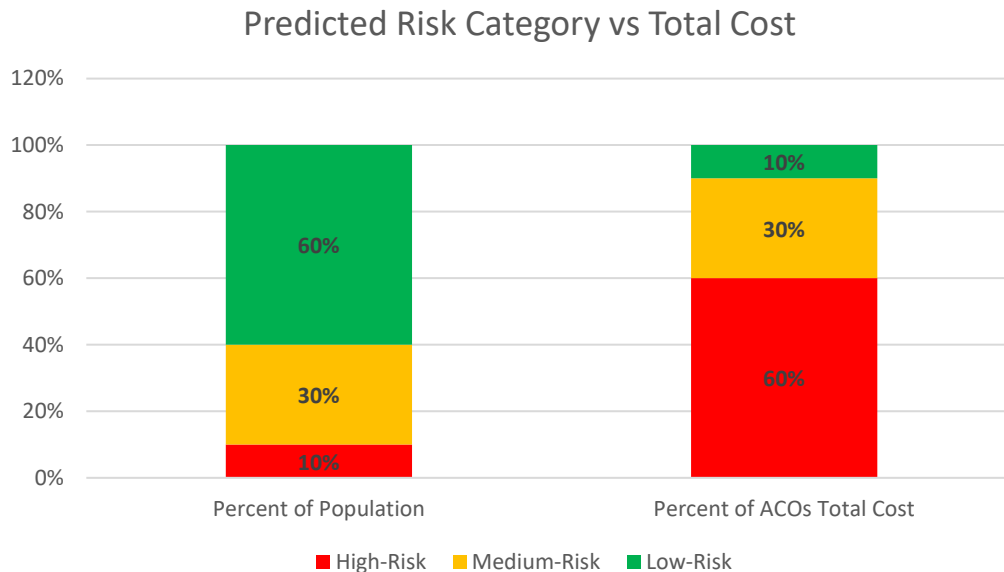
Performance Incentives

Knowing inpatient admissions, readmissions, and ED utilization were all areas we needed to address, we began to focus on prioritizing high risk patients and targeting them with Care Management efforts. We placed weighted focus on Care Management and Annual Wellness Visits for our Shared Savings distribution model beginning for PY2023.

Shared Savings Metric	Definition						Weighted by Attribution
Attribution	Credit will be given for client's Q4 attribution.						15%
Annual Wellness Visits	Tier	Performance	Credit	Tier	Performance	Credit	40%
	1	35% to 40%	15%	5	56% to 60%	75%	
	2	41% to 45%	30%	6	61% to 65%	90%	
	3	46% to 50%	45%	7	66% +	100%	
	4	51% to 55%	60%				
Quality	Tier	Performance	Credit	Tier	Performance	Credit	20%
	1	54.0 – 58.9	25%	1	44.0 – 48.9	25%	
	2	59.0 – 63.9	50%	2	49.0 – 53.9	50%	
	3	64.0 – 68.9	75%	3	54.0 – 58.9	75%	
	4	69.0 +	100%	4	59.0 +	100%	
	Manual Submission			EHR Submission			
Care Management	Tier	Performance	Credit	Tier	Performance	Credit	25%
	1	5% - 7%	15%	4	14% - 16%	60%	
	2	8% - 10%	30%	5	17% - 19%	80%	
	3	11% - 13%	45%	6	20% +	100%	

Identifying Patient Population for CCM

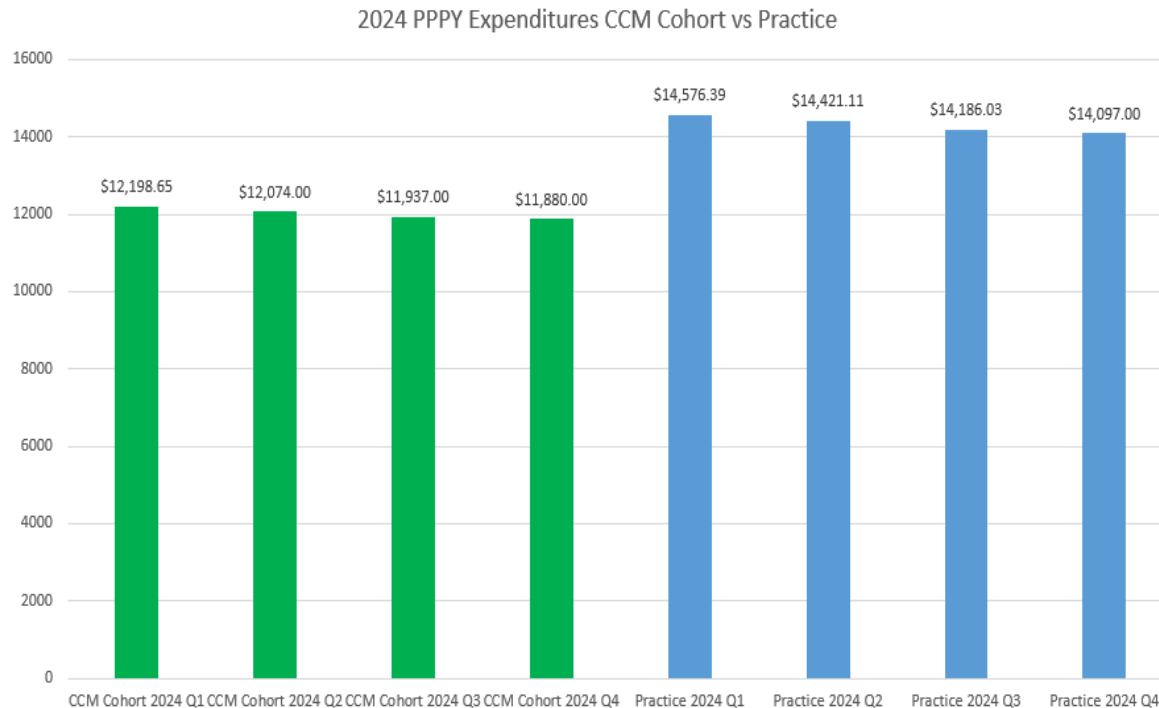
Understanding that the medium to high risk patient population makes up the bulk of healthcare spend, we worked to identify patient populations we felt would be impacted by Care Management services.



Partnership Results

With the patient cohort SARCOA worked with, we saw an increase in CCM enrollment while seeing a steady improvement in several utilization metrics.

- Readmission rates in 2024 CCM cohort 12.2% vs 15.1% for total Practice
- ED utilization improved dramatically from 2022 to 2024
- 2024 Total Cost of Care in CCM cohort was \$2,217 better than overall Practice patient panel





Community Care
SOLUTIONS



Results show the direct impact that increased communication and engagement provided by the Health Coaches between the patient population and the health care providers can have on quality metrics and patient outcomes.

Discussion / Questions?

Thank you!

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Save the Date!



Spring 2025 Conference

April 22–24, 2025

Hilton Baltimore Inner Harbor

[Registration is Open!](#)



Affinity Groups: Recently Restructured



- [Affinity Groups](#): peer-to-peer role-focused discussion groups our members can join to exchange information, ideas, and brainstorm on current issues.
 - **Operations and Executive Affinity Group**
Meets: January 21, 2025, July 22, 2025, and January 20, 2026, from 3–4 pm ET
 - **Data and Analytics Affinity Group**
Meets: January 28, 2025, July 29, 2025, and January 27, 2026, from 3–4 pm ET
 - **Clinical and Performance Improvement Affinity Group**
Meets: February 11, 2025, August 12, 2025, and February 10, 2026, from 3–4 pm ET
 - **Compliance and Legal Affinity Group**
Meets: February 18, 2025, August 19, 2025, and February 17, 2026, from 3–4 pm ET.
 - **Federal Government Lobbying Affinity Group**
Meets: February 20, 2025, April 17, 2025, June 18, 2025**, August 21, 2025, October 16, 2025, December 18, 2025, from 2–3 pm ET.
 - Participation is limited to NAACOS members and business partners that are registered federal lobbyists or policy professionals.

Deep Dive Roundtables



- **Deep Dive Roundtables** Topic-focused discussion groups for members to share best practices and design policy solutions on key topics across value.
 - **Patient and Community Engagement**
Meets: February 4, April 1, June 3, August 5, December 2, 2025 (1st Tuesday, bimonthly) from 2–3 pm ET.
 - **High Needs Patients**
Meets: February 18, April 15, June 17, August 19, October 21, December 16, 2025 (3rd Tuesday, bimonthly) from 2–3 pm ET.
 - **Medicare Advantage**
Meets: January 14**, March 18, May 20, July 15, September 16, November 18, 2025 (3rd Tuesday, bimonthly) from 1–2 pm ET.
 - **ACO REACH**
Meets: January 23, March 27, May 22, July 24, September 25, November 20**, 2025 (4th Thursday, bimonthly) from 12–1 pm ET.
 - **Rural and Underserved**
Meets: February 13, May 8, August 14, November 13, 2025 (2nd Thursday, quarterly) from 2–3 pm ET.
 - **Quality Implementation**
Meets: February 12, March 12, April 9, May 14, June 11, July 9, August 13, September 10, October 8, November 12, December 10 (2nd Wednesday, monthly) from 2–3 pm ET.