Partnership
to Align Social Care

A National Learning
& Action Network

Achieving Financial Stability

Module 2: Guide to Evaluating Revenue Opportunities for Community Care Hubs

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Introduction

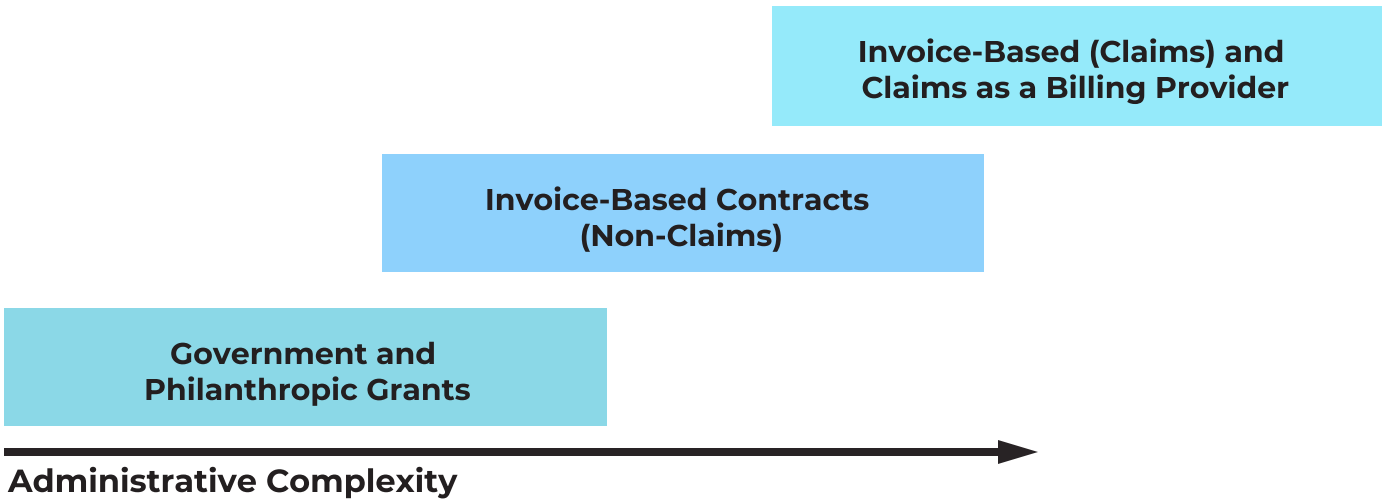
Community Care Hubs (CCHs) are social care delivery systems that offer value to both healthcare organizations and the community-based organization (CBOs) that are part of their network. As organizations consider becoming a CCH or existing CCHs chart a growth plan, they should develop a revenue strategy that can sustain both the cost of operating and growing the CCH infrastructure as well as the cost of delivering services through member organizations.

Experienced CCHs typically rely on a diverse and balanced portfolio of revenue opportunities, including grants, invoice-based contracts, and claims-based contracts. This helps ensure financial stability by having a wide range of funders, none of which it is overly dependent on. Yet, most CCHs do not have the full complement of infrastructure and capacity to be able to take advantage of all revenue types in their first few years. For example, a CCH might not have the staff or technical capacity to submit claims and manage a revenue cycle. Instead, they typically pursue funding opportunities for which they qualify while making strategic investments to build capacity to participate in the full range of revenue opportunities. This requires a CCH to intentionally pursue a variety of funding types that support various aspects of a CCH infrastructure, operations, and delivery of network services. In doing so, a CCH develops a blended and braided funding approach that makes it more possible to reach its future state aspirations of having a diverse and balanced portfolio of revenue.

This brief is designed to help new and growing CCHs understand and evaluate distinct types of revenue opportunities. For each opportunity, we discuss the requirements, benefits, and risks associated with the revenue type in the categories of infrastructure, compliance, and finance. The goal is for CCHs to focus their attention on revenue opportunities for which they are best suited while also planning for and building new capacity to be able to pursue all revenue types.

There are three CCH revenue types that will be discussed in this brief. Though not necessarily a comprehensive listing of all potential types of revenue which a CCH could access, they are among the three most common types of revenue that can support a CCH. They are introduced according to the level of administrative complexity that is required to secure and operationalize the revenue type, from least complex to most complex. They include:

- **Revenue Type 1:** Government and Foundation Grants
- **Revenue Type 2:** Invoice-Based Contracts
- **Revenue Type 3:** Claims-Based Revenue through Invoice-Based Contracts or as a Billing Provider



Top-Line Considerations for Each Revenue Type

Below are take-away messages that synthesize key considerations regarding the administrative complexity and corresponding requirements, risks, and benefits specific to each revenue type.

- **Revenue Type 1:** Government and foundation grants can fund a CCH to build its capacity and conduct activities which are not direct service, but important for building a CCH's infrastructure. Although these funds can be less sustainable and harder to predict, they are often less administratively complex than other sources of revenue and can help to establish a foundation (financial, technological, and operational) on which to build.

- **Revenue Type 2:** Invoice-based contracts allow a CCH to gain experience contracting with healthcare organizations, while not always requiring the more rigorous levels of contracting, technology, and accounting systems that Revenue Type 3 requires. Some healthcare and CCH organizations view this arrangement as a way to assess a partnership before moving it to a claims-based arrangement (Revenue Type 3).

- **Revenue Type 3:** Claims-based revenue through invoice-based contracts or as a billing provider are the most administratively complex, and therefore require the most resources to operationalize. Claims-based services require a higher level of integration into the systems that local healthcare provider and payer organizations use and can be difficult to initially implement. Once established, claims-based revenue can enable greater opportunities to evaluate the success of the partnership, the impact on patients served, and allow for heightened levels of collaboration between the healthcare organization and community-based CCH.

Revenue Type 1: Government and Foundation Grants

Table 1. Examples of funded activities: CCH planning activities, capacity building activities, community engagement, and service delivery pilots.

	Potential Considerations for Community Care Hubs (CCHs)
Infrastructure	**Benefits**: Builds capacity; expands programming; supports network building and community engagement. **Risks**: Requires administrative capabilities; increased administrative burden.
Compliance	**Benefits**: Does not require rigorous healthcare compliance measures. **Risks**: Increased monitoring and evaluation standards; necessitates transparent finance systems.
Financial	**Benefits**: Promotes diversified revenue streams; enhances budget flexibility. **Risks**: Chasing misaligned funds; requirement to match funding; difficult to predict and sustain.

What is this revenue type?

Grants are provided by governmental entities (such as federal, state, or local government agencies) and private foundations (philanthropic organizations) to support initiatives that align with their strategic priorities.

Why and when is this revenue type important?

Government grants and foundation funding can support a wider range of non-service activities (e.g., capacity building and community engagement) that would otherwise need to be covered by an organization's operating budget. This can help the CCH be more nimble, culturally responsive, and community driven in its approach to care coordination. This funding type often provides more flexibility in supporting a CCHs ability to engage in activities that enhance its credibility and help build trusting relationships with the community that typically are not directly compensated in a service contract (Revenue Types 2 and 3). This can include activities to understand current needs, gaps, services, partners, and resources in the region or community they serve, and to do so in a way where listening and partnering with the community, rather than doing to the community, is prioritized.

Community Care Hubs need funding to continually strengthen their ability to perform the six functions, or roles and responsibilities, of CCHs that are identified in the Functions of a Mature Community Care Hub. For instance, a CCH in earlier stages of development will likely need to establish leadership and governance functions by developing a board of governance with representation from key sectors of the community, bylaws for that board, and also decide whether the CCH will be a subsidiary of an existing organization, a newly formed organization, or another option altogether. Earlier stage CCHs are likely focused on building their organizational capacity, while

later-stage CCHs will focus on strengthening their existing capacity. Government grants and foundation funding often offer a revenue stream to support these types of activities.

What are some example services that could fit in this revenue opportunity?

Government and foundation funding can support a variety of activities. It is likely that this revenue type funds foundational capacity building, community engagement activities, and the delivery of services associated with early-stage CCH development. As a result, a CCH can implement pilots that help them establish an evidence base for their services. Activities that could be funded by government and foundation funding include, but are not limited to:

- **Planning activities** related to establishing leadership and governance, conducting an analysis of the healthcare marketplace to support strategic business development, and conducting assessments of local CBO's compliance with healthcare privacy and security requirements.
- **Capacity-building initiatives** to strengthen the organizational infrastructure (e.g., technology, staff, etc.), enhance program effectiveness, and expand service delivery capabilities of a diverse Community Care Network (CCN) comprised of CBOs. Philanthropic and grant funding can fund positions specifically dedicated to establishing a CCHs infrastructure, which can help accelerate the development of the CCH.
- **Fostering authentic partnerships** with CBOs, community members and the community-based workforce to foster change by guiding and advising on what is best for the community.
- **Service delivery** across a variety of domains, including case management, care coordination, housing assistance, food security programs, and transportation services. Other activities may include culturally responsive community outreach and education programs aimed at addressing social determinants of health and promoting healthy behaviors.

Example from the Field

Revenue Type 1: Government and Foundation Grants

HealthierHere, serving as the Community Care Hub for King County region in Washington state is an Accountable Community of Health (ACH). HealthierHere as an ACH remains committed to convening and engaging a regional network of more than 150 organizations toward more equitable health.

HealthierHere received funding from the King County Veteran's Seniors and Human Service's levy to further their community engagement strategy, building out technology infrastructure to connect community and clinical partners.

The funding supported engagement activities with community-based partners to build out their governance and shared decision-making structure. This funding was critical to further HealthierHere's Network build, ensuring investments were made into community partners critical to the governance model design and implementation.

What are the risks, requirements, and benefits associated with this revenue opportunity that CCHs should consider?

Infrastructure

- **Benefits:** There are a variety of benefits to pursuing government and foundation grants. These funding types can build capacity to support organizational growth and development by providing resources for staff training, technology upgrades, and infrastructure enhancements, which contracts alone may not be sufficient to fund. Government and foundation grants can also help expand programming by funding the expansion of a CCH's service offering and their ability to reach underserved populations. Lastly, CCHs can use this type of funding to support its network building and community engagement efforts, which is one of the six functions of a CCH. Building a strong network of service providers cannot happen without authentically engaging community stakeholders and collaborating effectively. A CCH will need to engage diverse community perspectives to ensure they understand the complex landscape of their region. They will ultimately increase their value proposition if they deeply understand community needs, gaps, services, partners, and resources in the region or community they serve. Grants may support partnerships or collaborations with other organizations, leading to knowledge-sharing, resource pooling, and the development of a broader network of stakeholders within the community.

- **Risks:** There are also risks associated with pursuing and securing government grants and foundation funding, depending on the focus and expectations of the funder. Managing and implementing funded programs may require additional staff, resources, or infrastructure that the CCH may not currently possess. Scaling up operations to meet grant requirements could strain existing organizational capacity or deviate attention and resources away from strategic priorities. Additionally, a CCH might experience increased administrative burden from submitting complex grant applications, documenting information according to grant specifications, and other reporting obligations, especially if it does not have experience working with grants.

Compliance

- **Benefits:** Government grants and foundation funding typically are not healthcare contracts, and therefore they typically do not require the same level of rigorous healthcare compliance practices required for other revenue types. At the same time, this revenue type can help a CCH establish those stringent reporting and compliance requirements that they will eventually need to adopt to secure the other types of revenue described in this document and which involve contracting with healthcare organizations.

This can also help a CCH adopt best practices in fiscal management, program implementation, and performance measurement. Similarly, grant-funded projects often require monitoring and evaluation at some level. CCHs can embrace this as an opportunity to develop continuous quality improvement and innovation practices.

- **Risks:** The risks associated with government grant and foundation funding may not necessarily have to do with healthcare privacy and security laws, but there are still other types of risks with this revenue type. First, grants often require monitoring and evaluation of program outcomes, which may require the CCH to invest in data collection systems, performance metrics, reporting mechanisms, and outside evaluation contractors. Ideally, evaluation requirements should be funded as part of the grant opportunity, but these costs can be hard to estimate and there is generally a cap on the proportion of grant funds that can be spent on these activities. This may result in CCHs needing to seek additional grant support specifically designated for evaluations. In addition, transparency in fiscal management and program implementation is essential for maintaining trust with funders and stakeholders. CCHs may need to invest in additional staff to manage finances, outside audits, and software to track/manage grant funding. A real or perceived lack of transparency or improper use of funds could damage the reputation and credibility of the CCH.

Financial

- **Benefits:** Government grant and foundation funding play a critical role in promoting a diversified revenue portfolio for a CCH. This revenue type serves as an additional source of income that will likely always be a part of a CCH's revenue mix and will represent a larger percentage of the revenue mix early in the CCH's development while it is still working to secure funding from healthcare contracts. In this way, this revenue type reduces reliance on invoice and claims-based funding streams (Revenue Types 2 and 3) and enhances financial stability for the CCH. This revenue type also allows CCHs to allocate resources to critical areas that funding from healthcare contracts may not and without having to tap into operational budgets; areas such as program expansion, staff training, and infrastructure improvements.

- **Risks:** One of the primary financial risks is that CCHs might over rely on this revenue type, which can result in a lack of diverse revenue sources, or a CCH diverting from its central mission to try and fit their work to the funding rather than fitting the funding to their core work. Fluctuations in funding availability or changes in funding priorities could impact the financial stability of the CCH or result in the pursuit of strategies that are misaligned with their core mission. In addition, some grants may require matching funds or cost-sharing, which can

strain the financial resources of the CCH if not adequately planned for or create additional staff time burdens due to fundraising demands. Lastly, it is difficult to predict when grant funding will be available and most grant opportunities are time-limited, creating challenges sustaining services once the funding period ends. Grants are particularly well-suited to one-time investments or capacity building activities whose cost is time limited or can later be supported through a broader infrastructure funding.

Revenue Type 2: Invoice-Based Contracts

Table 2. Examples of funded activities: Evidence-based or informed services that will be most appealing to healthcare organization partners.

	Potential Considerations for Community Care Hubs (CCHs)
Infrastructure	**Benefits:** Technological capabilities and organizational knowledge required to activate this revenue type is more similar to Revenue Type 1 than to Revenue Type 3. **Risks:** Likely requires more specialized and HIPAA secure technologies for case management and community-based care coordination compared to grant-funded projects.
Compliance	**Benefits:** Safeguards to put in place are similar to that needed for Revenue Type 3, and therefore position a CCH to pursue more than just this revenue type **Risks:** May require a CCH to learn about and implement healthcare data security and privacy measures, which is time-and-resource intensive; CCH could be exposed to greater liability in areas such as a cybersecurity breaches.
Financial	**Benefits:** Less complicated for both the healthcare organization and CCH to execute than Revenue Type 3. **Risks:** Operates outside of a healthcare payer's claims infrastructure and therefore will not count towards the Medical Loss Ratio.

What is this revenue type?

Invoice-based contracts for non-claims-based services is the second revenue type that a CCH might explore and likely the second most accessible type of revenue after Revenue Type 1. With this revenue type, CCHs contract with a healthcare organization to deliver specified services to an agreed upon population. Payment for those services can be provided by the healthcare organization to the CCH according to a predetermined payment structure (see A Health Plan's Guide to Paying CBOs for Social Care for example payment structures). While this partnership arrangement may sound similar to a grant that a CCH might receive from a healthcare organization, there are typically two features that make invoice-based contracts distinct: 1) the CCH must document the quantity, type, and date of the services that were delivered as part of the payment transaction with the partnering healthcare organization; and 2) rather than receiving a lump sum of funding up front, these partnerships can incorporate a variety of payment structures into the contractual arrangement, including fee-for-service, capitated arrangements, or pay-for-performance.

Why and when is this revenue type important?

Invoice-based contracts are an important part of a CCH's revenue mix. They can be less complicated and administratively burdensome to execute for the CCH, and sometimes the healthcare organization, than a claims-based arrangement. Therefore, some organizations view this arrangement as a way to assess a partnership before moving it to a claims-based arrangement. In other cases, there may not be formal healthcare benefits and associated billing codes established that support the services to be rendered, and as a result, an invoice-based contract is the primary alternative available to the organizations if they want to move forward in partnering. This revenue type builds on the capabilities that a CCH has established through Revenue Type 1 (government grants and foundation funding) but pushes the CCH to incrementally add to those capabilities and diversify its sources of revenue. While invoice-based contracts will not be the right alternative for every partnership opportunity, having it as an option among other revenue types can provide a CCH with flexibility to meet partners where they are at and get to 'yes' in an arrangement.

What are some example services that could fit in this revenue opportunity?

The types of services that can be delivered under an invoice-based contract are varied. These contract arrangements can support traditional community-based chronic disease prevention and management interventions, care transitions, community-health worker/navigator supports, or delivery of medically tailored meals, as some examples. Since the contracts are established with healthcare partners and resemble aspects of more traditional healthcare contracts (in terms of payment structure and documentation of services), it is typically important that the services are evidence-based or informed to secure and establish invoice-based contracts. These types of contracts can be established with health plans, healthcare provider organizations, or state Medicaid programs. For instance, some Area Agencies on Aging or Centers for Independent Living contract with the state Medicaid program through invoice-based contracts to deliver Home and Community-Based Long-Term Services and Supports to individuals with various physical and cognitive disabilities.

What are the risks, requirements, and benefits associated with this revenue opportunity that CCHs should consider?

Infrastructure

- **Benefits:** The technological capabilities and organizational knowledge required for invoice-based contracts more closely mirrors the infrastructure required for traditional grants (depending on the payment structure) as compared to claims-based revenue options outlined in Revenue Type 3. As such, the threshold for establishing the operational infrastructure to activate this revenue type may be lower and more accessible for a CCH.

- **Risks:** Invoice-based contracts will require documentation at some level of detail on the services provided in order to generate and support an amount owed to the CCH. If a CCH's partner is a health plan, the documentation will likely need to include the type of service provided, the date of service, the person rendering the service, and the number of units or time spent providing the service. If the CCH's partner is a healthcare provider organization, additional documentation about the service that was rendered may be needed so it can be integrated back into the patient's medical record and be viewable by the patient's healthcare provider. There is technology infrastructure needed to operationalize the above-mentioned scenarios. To document the services, a CCH might source specialized software for case management or community-based care coordination. Alternatively, a CCH might use software like secure versions of Excel or Smartsheet to document services if they are earlier in their CCH journey and the necessary physical and technical safeguards are in place along with any necessary agreements (e.g., Business Associates Agreement). Lastly, a CCH will likely need infrastructure to track and reconcile invoices that have been paid and invoices that are still outstanding.

Example from the Field

Revenue Type 2: Invoice-Based Contract

The YMCA of Metropolitan Milwaukee contracted with a regional health plan in 2018 to offer the Diabetes Prevention Program as an Umbrella Hub Arrangement with a payer. While the invoiced-based contract began as a lump sum per-member payment structure, after several years of demonstrating program efficacy-- helping participants achieve weight loss and attendance milestones--the Y requested to migrate toward a performance-based contract reflecting a higher financial upside.

The Y submits individual, patient-level data including weight and activity minutes to the payer for documentation purposes--therefore, HIPAA compliance is a requirement of the contract arrangement.

Because the program is offered to participants as a wellness benefit -- instead of a medical benefit -- the payer prefers to maintain an invoice-based contract with the Y rather than transition to a claims-based payment arrangement.

Compliance

- **Benefits:** The compliance requirements for a CCH do not vary that much for an invoice-based contract compared to Revenue Type 3 outlined in this resource. Even in an invoice-based contract with a healthcare organization, CCHs will manage protected health information (PHI), need to have the proper safeguards in place to protect that information, and need to execute a Business Associates Agreement (BAA) in many cases.

- **Risks:** Depending on the maturity and strategic business decisions it makes, a CCH may or may not be a HIPAA-covered entity. Even so, in order for a CCH to enter into an invoice-based contract with a healthcare organization, it will likely be asked to execute a BAA. Under U.S. HIPAA rules, when an organization establishes a BAA with a covered entity, it agrees to comply with certain HIPAA Rules. As a result, it will be important for a CCH that plans

to pursue invoice-based contracts with healthcare organizations to develop appropriate administrative, physical, and technical safeguards to protect PHI and that there are formalized organizational policies, procedures, and decision-making protocols. The CCH may also be asked to provide proof of cyber security insurance. This protects both the CCH and the healthcare partner in the case of a cyber security breach or incident. Often payers will require a minimum amount of cybersecurity insurance coverage as part of their standard contracting. Learning about these security and privacy rules to which the healthcare sector is subject can be a time-consuming process that requires resources. CCHs should be prepared to conduct formal risk assessments to identify vulnerabilities in their adherence to these rules and then invest time and sometimes money into implementing the appropriate measures to mitigate any risks. Building a compliance program and a culture of compliance is an ongoing process. It is possible that existing staff will need to incorporate new functions into their roles, additional staff at the CCH will need to be hired whose primary responsibility is overseeing the compliance program, or both.

Financial:

- **Benefits:** Invoice-based contracts can be less complicated for both the healthcare organization and CCH to execute. For this reason, the partnership can get to activation quicker and this contracting method can serve as an appealing way to pilot a partnership between the contracting organizations, evaluate their impact on a smaller population sample, and then make informed decisions on whether to scale the partnership. These factors may enable the possibility that invoice-based revenue comprises a meaningful percentage of the revenue mix for a CCH.

- **Risks:** While invoice-based contracts may be a path of lesser resistance for a CCH to pursue when contracting with a health plan, it can be the opposite for a health plan. Health plans track the services rendered to their members, the costs of those services, and the outcomes and benefits derived from those services through claims. Their technology infrastructure is set up to ingest claims files and translate the data within those files into meaningful information that can guide future investments in new benefits and optimization of existing benefits for their members. An invoice-based contract operates outside of this infrastructure because it is not based on claims data, and therefore it will be more challenging for a health plan to evaluate the impact of the partnership with a CCH. In addition, it will be difficult for them to count the services provided through the partnership as medical/quality improvement costs and not administrative costs in their medical loss ratio (MLR). These reasons can serve as barriers to securing invoice-based contracts for CCHs. Even when a health plan agrees to invoice-based contracting, it is often with the expectation that the arrangement will evolve into a claims-based arrangement within some number of years. Therefore, it would be risky for a CCH to build out their CCH infrastructure with the expectation that invoice-based contracts will sustain the entire operation.

Revenue Type 3: Claims-Based Revenue through Invoice-Based Contracts or as a Billing Provider

Table 3. Examples of funded activities: care management healthcare services; preventive healthcare services which have been established as healthcare benefits.

	Potential Considerations for Community Care Hubs (CCHs)
Example Services	Services that can be delivered under general or direct supervision of another provider; services that are directly provided by the CCH (e.g., care management, chronic disease management training etc.)
Infrastructure	**Benefits:** Can leverage existing systems/processes in pass-through contracts to document care. **Risks:** For claims as a direct billing provider, revenue-cycle management technology will either have to be purchased or outsourced to a third party to facilitated claims submission to payers, which often requires additional staffing. Claims-based billing also requires the CCH to have knowledge and staffing to manage eligibility for services, coding accuracy, claims appeals and grievances, and quality assurance activities.
Compliance	HIPAA compliance is the same as invoice-based (non-claims) contracts; where the CCH/CBO is billing directly via claims, it may be liable for compliance with insurance program (e.g., Medicaid) obligations.
Financial	**Benefits:** Established healthcare benefits with associated reimbursement rates make it easier to predict the volume of services that must be rendered to achieve a break-even point. **Risks:** Pass-through payments will need to be negotiated with the provider and could be minimal; claims payments will likely be delayed by several months after date of service.

What are these revenue types?

Some services that CCHs provide are already a formal healthcare benefit with associated billing codes and reimbursement rates. There are two different paths for a CCH to contract for these healthcare services. The first is to directly contract as the billing provider with payers (e.g., Medicaid, Medicare, Commercial) and receive either fee-for-service, capitated, or other alternative payment model reimbursement for the provision of agreed upon services. Services are billed on a regular basis through the submission of paper or electronic claims, and payment is based on an agreed upon fee schedule negotiated during contracting. In this scenario, a CCH would need to meet the requirements (e.g., staffing and licensure) that make an organization eligible to bill for a service.

The second path to accessing claims-based revenue is via invoice-based contracts with healthcare provider organizations. In this scenario, the CCH will contract as a third-party organization delivering the service under the supervision of the healthcare provider. The healthcare provider is the billing provider that submits claims to health plans for the service rendered, and the CCH is reimbursed by the healthcare provider organization on the back end via a Third-Party Organization, pass-through contract.

Claims-based revenue as either the billing provider or via an invoice-based contract will require similar levels of capacity at the CCH and involve similar levels of risk. As such, this section will describe these together as Revenue Type 3.

Why and when are these revenue types important?

Claims revenue through invoice-based contracts: These types of arrangements can be an important revenue stream for CCHs for a number of reasons. As a starting point, healthcare is local. This type of partnership arrangement brings together two local organizations and can have the multiplying effect of reinforcing both organizations as trustworthy organizations, which can build momentum for future contracts.

This revenue type does require a higher level of integration with local healthcare providers that can be challenging to implement, but once integration is established, it can enable important opportunities to evaluate the partnership's success and the impact on patients served, and facilitate additional collaboration between the healthcare and community-based CCH. Also, this partnership arrangement limits the need for a CCH to be the billing provider and therefore build out the corresponding infrastructure that is required to bill for healthcare services directly. While the CCH would still need to reconcile accounts receivable against the service delivered and invoiced, they would not need to submit claims and manage denied submissions with payers.

Claims revenue as a billing provider: Claims-based reimbursement can provide a more stable and consistent revenue stream for CCHs compared to grant funding, which is often time-limited. Once benefits and reimbursement rates are established, it is easier for a CCH to predict the volume of services they would need to provide to break even. However, reimbursement amounts for many of the services which CCHs can render and bill for are moderate amounts. Therefore, CCHs should rigorously evaluate the potential return on investment for their organization when considering or entering this type of contracting relationship, including whether there are opportunities to blend and braid funding from other sources.

What are some example services that fit in this revenue opportunity?

Claims revenue through invoice-based contracts: To date, many of the healthcare services that lend themselves to pass-through contracts have been introduced and used in Medicare, but once the billing codes are established, they are also available for use by Medicaid programs as well. These services include, but are not limited to, care management codes, such as Community Health Integration, Principal Illness Navigation, Chronic Care Management, and Transitional Care Management.

These codes can be billed under the general supervision of the billing healthcare practitioner.

This means that the billing healthcare practitioner provides oversight of the personnel delivering the service, including ensuring that a treatment plan is in place, personnel delivering the service have access to the plan, and that there is regular interaction between the provider and the personnel delivering the services to achieve the treatment goals in the medical record. It does not require, however, that the personnel delivering the service be co-located with the billing healthcare practitioner. Instead, personnel employed by the CCH that are delivering the service under the general supervision of the billing healthcare practitioner can work with the client in community settings as long as there are regular updates to the billing healthcare practitioner providing general regarding the progress towards achieving the defined treatment goals in the medical record.

Example from the Field

Revenue Type 3: Claims-Based Revenue through Invoice-Based Contracts

Community of Care for Older Adults with Complex Care Needs (CoC) is a partnership between Region IV Area Agency on Aging (AAA), Corewell Health South and a network of CBOs, with Region IV AAA serving as the CCH in St. Joseph, Michigan.

The CoC project embeds AAA social care staff in medical care teams to overcome social determinants of health barriers, improve health and reduce costs for older adults with multiple chronic conditions. Corewell Health and Region IV AAA applied for and received a grant from the Michigan Health Endowment Fund to launch this work, establish a partnership, and utilize Medicare-billable codes to support the CoC beyond the initial grant-funded launch.

Today, Corewell Health serves as the billing provider of Medicare Part B Chronic Care Management (CCM) services. Region IV AAA subcontracts with Corewell Health to provide CCM services for two physician practices, and the AAA invoices Corewell Health for services provided.

Source: https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2024/08/8-20-USAging-Success-Story-RIVAAA.pdf

Conversely, it is also possible that a CCH could play a role in the delivery of services that require direct supervision of the billing provider. Direct supervision requires the billing provider to be co-located with other personnel on the care team and supervise delivery of the service. For instance, a Community Health Worker employed by the CBO and subcontracted to the partnering medical group might deliver defined, billable service(s) onsite at a primary care office. As such, they would be compensated through this type of contracting arrangement with the billing provider.

Claims revenue as a billing provider:

There are a number of preventive services that have been established as healthcare benefits under Medicare and/or Medicaid. These include, but are not limited to, the Diabetes Prevention Program, Diabetes Self-Management Training, Medical Nutrition Therapy, and

Health Coaching. If the CCH is the billing provider for any of these services, it is important to understand that that payers have strict rules and regulations around the type of individuals or organizations are recognized as providers and that can deliver services to the payer's members. As such, any CCH must be prepared to demonstrate that affiliated service providers are adequately licensed to provide the services for which they plan to bill. Medical services such as primary care, mental and behavioral health, or chronic disease management services require an appropriately licensed professional on staff to provide this type of care. Provision of social care services such as transportation, housing support, food insecurity support, and screening and navigating for social determinants of health by CHWs could also be reimbursed by claims in some states with Medicaid benefits in place.

The details of how social care services are reimbursed may differ by payer and/or state depending upon the population that is covered under the contract (e.g., Medicare/Medicaid vs. commercially insured populations). Under this type of contracting a set of American Medical Association (AMA) approved Current Procedural Terminology (CPT) codes would be used to reimburse specific social services. The CCH might also have to demonstrate to the payer that affiliated individual providers, such as CHWs, have the correct certifications required to provide the service as defined by the CPT code details and requirements.

Example from the Field

Revenue Type 3: Claims Revenue as the Billing Provider

MANNA (Metropolitan Area Neighborhood Nutrition Alliance) is a CBO providing nutritious, medically appropriate meals for the residents of Pennsylvania and Southern New Jersey with serious illnesses such as cancer, kidney disease, diabetes, HIV/AIDS, and other conditions.

In 2014, MANNA began transitioning from grants to healthcare contracting as the billing provider. During this transition, the organization hired a part-time medical billing specialist and eventually expanded the team to include three full-time medical billers. The organization also increased internal compliance standards after finding gaps that an early audit exposed.

MANNA hired staff focused on privacy and security, and transferred client data from a server to a cloud-based platform to ensure software meets industry standards. Today, MANNA is a member of a healthcare information exchange (HIE) and can accommodate bi-directional data exchange. The organization has implemented numerous claims-based contracts serving as the billing provider directly submitting claims to Medicaid Managed Care Organizations.

What are the risks, requirements, and benefits associated with this revenue opportunity that CCHs should consider?

Infrastructure (Risks, Requirements, and Benefits)

- **Claims revenue through invoice-based contracts:** The CCH must document and share information that the provider needs to complete patient care plans and submit claims. This would likely require either an ability to send information from current systems electronically to the provider, or it could require the ability to input information directly into the provider's data systems , if that is preferred. Depending on the types of information required, the CBOs could utilize their current case management systems to provide information for care planning and possibly also billing.

There would also need to be regular meetings between providers and the CCH, which would require sufficient staff capacity to deliver services and coordinate with provider staff. Financial staff would also be responsible for reconciliation of services delivered vs revenue received from their partnering healthcare provider organization.

- **Claims revenue as a billing provider:** If the CCH is pursuing claims-based reimbursement directly with payers, the infrastructure needs increase. Claims-based reimbursement will require the submission and processing of claims to and payments from payers. This can be done either by paper or electronic submission, depending on the payer requirements, the latter of which will also require the correct software and technology to complete. If done in-house, the organization will need to hire revenue cycle management (RCM) professionals to monitor claims and payments daily, and to manage eligibility, denials, appeals and grievances. Alternatively, RCM services can be outsourced (at a cost) to a third party to lessen the administrative burden and infrastructure investment needed until operations are appropriate scaled to support an in-house function.

Some states are still considering models for incorporating payment for social care services into the healthcare system. As a result, in states that are still in an emerging phase, it is possible that provider types are not yet established for CBO services and that the CBOs are credentialed directly by the health plan. This may result in health plan's being more responsible for designing processes that dictate how they work with CCHs and CBOs, rather than having uniform processes established by the state Medicaid program. For example, each payer may have a different process for CBOs to enroll as providers, determine client eligibility for services, manage claims submissions and denials, and others.

Compliance (Risks, Requirements, and Benefits):

- **Claims revenue through invoice-based contracts or as a billing provider:** The CCH will be considered a covered entity or business associate of a covered entity in either contract type. As such, they are required to comply with all HIPAA and HITECH rules regarding privacy and security of personal health information. While this can take time, achieving HIPAA compliant adds credibility to the organization, especially with other health sector partners. As a billing provider, CCHs will be required to have a National Provider Identification (NPI) number in order to submit claims. CCH's will also need to ensure that they are meeting requirements for those NPIs (e.g., taxonomy code, etc.).

Financial (Risks, Requirements, and Benefits):

- **Claims revenue through invoice-based contracts:** Adding invoice-based arrangements allows CCHs to diversify financial sustainability strategies and to provide a more

consistent source of funding than grants alone. However, the CCH should consider that as the billing provider managing the administrative burden associated with submitting and tracking claims, a healthcare partner may withhold a portion of the billable revenue to cover their administrative costs. As a result, it is important to ensure that enough revenue can be generated to support the costs of both partners. The amount of revenue that is passed through to the CCH by the billing provider will vary depending on the provider with whom the partnership is created and on the services that are provided. The CCH may be able to negotiate with the provider partner regarding the amount that is passed through to them; in fact, it is possible the provider could rely on more than the pass-through amount to help fund the partnership (e.g., other operating funds, etc.).

- **Claims revenue as a billing provider:** The administrative costs of providing claims-based services can be quite high for smaller CCHs or CCHs just starting to bill directly for claims-based services. As such, some CCHs might consider using a third party to process claims, which may cost less for the organization than bringing the skills and resources in-house. Ultimately, the costs and benefits will depend on the number of claims processed and the corresponding fees that third-party vendors charge. As part of assessing vendor costs, the CCH should understand the number/volume of anticipated clients served (on a monthly, quarterly, and annual basis) and the rates and/or value-based contracting terms offered by payers. In doing so, they will be able to assess the anticipated costs against projected revenue for providing the services and if they can meet their financial goals. At a minimum, the CCH should ensure coverage for direct and indirect costs associated with delivering the services. Ideally, the CCH is able to cover all costs of the service and be afforded a margin.

  Finally, it is likely that payments are made retrospectively and will have a delay due to the necessary processing on the payer side. Further delays can occur if there are errors either on the provider or payer side. Organizations need to build this delay in payment into their budgeting process because it may prevent them from

Example from the Field

Government Support of Revenue Type #3: Claims-Based Revenue as a Billing Provider

As part of their **Medicaid 1115 Demonstration Waiver, New York State** is introducing several initiatives to promote health equity and reduce healthcare disparities in the state's Medicaid population.

Included is funding to support the creation of Social Care Networks (SCNs), or Community Care Hubs, which will facilitate the delivery of services to address social needs such as nutrition, housing, transportation, and case management for eligible Medicaid members. HRSN case management services and referrals to state, federal and local program will be reimbursed through the Department of Health (DOH) and will be offered to all Medicaid members.

A second level of support for populations with complex health and social needs (e.g., individuals with substance abuse or mental health issues, children with chronic conditions, homeless individuals) will allow SCNs to be reimbursed as providers through contracts with Medicaid MCO, and a DOH established fee schedule.

having a flow of cash to support services. To overcome this, CCHs might negotiate an up-front payment that provides an initial injection of financial resources into the delivery of services. In addition, as they gain experience with claims-based reimbursement, there may be an opportunity to negotiate higher reimbursement rates through alternative payment models that allow the organization to receive an incentive for reaching certain quality or cost targets.

Summary Table

	Government and Philanthropic Grants	Invoice-Based Contracts (Non-Claims)	Claims-Based Revenue through Invoice-Based Contracts or as a Billing Provider
Example Services	CCH planning activities, capacity building activities, community engagement, and service delivery pilots.	Evidence-based or informed services that will be most appealing to healthcare organization partners	Services that can be delivered under general or direct supervision of another provider; preventive healthcare services (e.g., Diabetes Prevention Program) that are billed directly by the CCH
Infrastructure	**Benefits:** builds capacity; expands programming; supports network building and community engagement **Risks:** requires administrative capabilities; increased administrative burden	**Benefits:** technological capabilities and organizational knowledge required to activate this revenue type is more similar to Revenue Type 1 than Revenue Types 3 **Risks:** requires more specialized and HIPAA secure technologies for case management and community-based care coordination.	**Benefits:** sets a CCH up to capitalize on all possible revenue types. **Risks:** requires a higher level of financial reconciliation that is specialized to healthcare, leading to either investment in RCM technology or outsourcing RCM to a third party to submit claims to payers directly
Compliance	**Benefits:** does not require rigorous healthcare compliance measures **Risks:** increased monitoring and evaluation standards; Necessitates transparent finance systems	**Benefits:** HIPAA Compliance shows commitment of organizations to healthcare standards **Risks:** requires a CCH to learn about and implement healthcare security and privacy measures, which is time-and-resource intensive; would require a BAA to be in place	Same as Invoice-based (Non-Claims) Contracts
Financial	**Benefits:** promotes diversified revenue streams; enhances budget flexibility; **Risks:** chasing misaligned funds; requirement to match funding; difficult to predict and sustain	**Benefits:** less complicated for both the healthcare organization and CCH to execute than Revenue Type 3 **Risks:** operates outside of a health plan's claims infrastructure and therefore will not count towards their Medical Loss Ratio	**Benefits:** established healthcare benefits with associated reimbursement rates make it easier to predict the volume of services that must be rendered to achieve a break-even point. **Risks:** standing up systems to manage revenue cycle and reconcile the services rendered against the accounts received is costly and unfamiliar at first to a community-based organization like a CCH

Conclusion

The revenue opportunities described in this document are not necessarily exhaustive (for example, individual donations were not mentioned), but they do represent what should be a significant percentage of a CCHs revenue mix. There is not necessarily a linear path that a CCH must follow when building out their portfolio of revenue, but it is fair to say that the level of administrative complexity increases from Revenue Type 1 to Revenue Type 3, and therefore many CCHs often secure more revenue from Revenue Type 1 (least administratively complex) earlier in their journey as compared to the other two.

However, these revenue types can be complementary. Revenue from government grants and foundations will likely continue to comprise a portion of a CCH's revenue mix, and CCHs can simultaneously pursue revenue from invoice-based contracts (Revenue Type 2) or claims-based contracts (Revenue Type 3). Deciding when and which type of revenue opportunity to pursue is part of a broader set of activities that a CCH should engage in as part of fulfilling one of the six core functions of a CCH - strategic business development - outlined in the Partnership report, Functions of a Mature Community Care Hub.

Partnership
to Align Social Care

A National Learning
& Action Network

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The Partnership to Align Social Care ("Partnership") is a national learning and action network whose purpose is to advance the alignment of healthcare and social care service delivery to individuals through contracted partnerships between healthcare entities and social care providers, particularly community-based organizations organized into networks led by community care hubs. The Partnership consists of leaders from across the healthcare and social care sectors, including health plans, health systems, providers, community-based organizations, national associations, and government. The Partnership has constituted a cross-sector planning committee and working groups in the areas of contracting, billing and payment, and community care hubs to co-design standards, resources, and tools to accelerate healthcare - social care collaborations in practice. For more information about the Partnership to Align Social Care, visit www.partnership2asc.org.

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