RESOURCE —

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Health Systems and Community Care Hubs

A Partnership for Meeting Patients' Social Needs

Partnership to Align Community Care

partnership2acc.org

Introduction

Health care delivery systems are being held accountable for identifying and addressing patients' health related social needs (HRSNs), but do not typically offer the actual social services required to meet those needs. It is critical for health systems to partner with the community-based organizations (CBOs) and agencies that do offer these services and support them in building capacity to meet the demand. The Community Care Hub (CCH) model offers an organized, sustainable blueprint for meeting patient social needs by coordinating health care provider and payer organizations with CBOs and agencies into financially sustainable community-centered networks.

The Imperative for Health Care

Research demonstrating that 80% of the factors affecting health outcomes occur outside of clinical care[1] clarified that policy, systems, and environmental change and a broader set of patient and community services are needed to improve outcomes and decrease the cost of care. This understanding has contributed to the slow but steady emergence of value-based care[2] and is increasingly incorporated into regulatory and accreditation requirements for health care entities.

Federal and state health care policy has demonstrated an intention to recognize and address patient's HRSNs as part of the payment and delivery system. At the federal level, CMS released its Framework for Health Equity 2022-2032,[3] Medicare rules requiring hospitals to screen all inpatient patients 18 years or older for HRSNs,[4] and billing codes to address HRSNs using a community-based workforce.[5] At the state level, section 1115 waivers (also known as Medicaid waivers) had been approved in 19 states and were pending in 12 more as of November 2023.[6] Additionally, 35 of 48 states reported a social determinants of health policy in their fiscal year 2022 managed care organization contracts.[7]

Accreditation programs such as The Joint Commission and the National Committee for Quality Assurance have implemented similar changes. Health care provider organizations are now required to screen for and address a patient's HRSNs through these respective accreditation programs.[8,9]

The increased focus on addressing HRSNs via health systems is a positive step toward acknowledging that health outcomes are heavily influenced by factors beyond the four walls of a doctor's office. Yet, health and social care delivery systems are not currently designed to collaboratively address patients' HRSNs at scale. Many health systems have invested in technology platforms that facilitate identification of community resources and closed-loop referral to those resources offered by CBOs. These are important tools but are only effective when those CBOs have capacity to accept referrals and meet the increased demand.

The infrastructure to provide social care interventions largely resides in the community rather than with health systems. Many CBOs provide services that could add value for health care payers and providers, but obstacles exist to realizing that value. The non-profit, faith-based, and governmental entities that most often deliver these social care services can lack the coordination and sustainable funding mechanisms that enable the longer-term planning and scaling necessary for the large populations cared for by health systems. In addition, establishing formal contracts with health care provider and payer organizations requires infrastructure and subject matter expertise around topics such as health care privacy laws and billing, which many individual CBOs do not have. Integrating health care and community sectors requires a solution that ensures the value that community-based services provide to health care provider and payer organizations can be measured, monitored, and reimbursed.

Community Care Hubs as a Solution

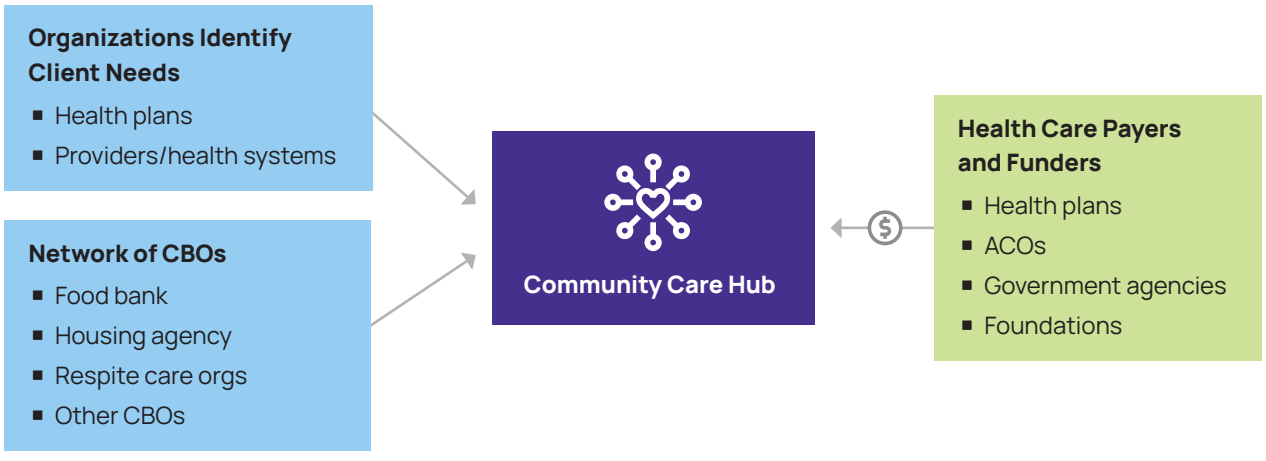
Community Care Hubs (CCHs) are a promising solution for alleviating the challenges around coordination of care, scalability, and impact. A CCH is a legal entity (or arm of an existing legal entity) that remains community-focused as it organizes and supports a network of CBOs providing the services that address HRSNs, such as food banks, housing providers, and Area Agencies on Aging. A CCH centralizes administrative functions and operational infrastructure required for efficient, sustainable network operations - most importantly, health insurance payer engagement, contracting, and billing for the purpose of bringing revenue to CBOs. While CCHs perform referral management to receive and send client information, that is one function among many that are focused on the larger goal of enabling payment to CBOs for the delivery of social care services. To this end, additional CCH services include information technology and security, data collection and reporting, and more - much like a Clinically Integrated Network administrative office centralizes functions on behalf of health care provider organizations participating in its network.

Establishing a CCH requires an investment of time, energy, and resources that should be intentionally vetted by local stakeholders. This investment returns value to health systems by rendering social care services that meet their patients' HRSNs and positively impact health outcomes, clinical cost, and quality. Value is also added across a variety of clinical and non-clinical functional areas within a health system, such as:

I. Provide a coordinated network of local social care delivery systems: As providers are increasingly required to screen patients for HRSNs and address the needs of those who screen positive, they want to know that there are local resources available to which they can refer patients. Asking patients about personal topics like HRSNs without having solutions available for them can risk trust in the patient-provider relationship and causes providers' stress. CCHs can provide a network of local CBOs ready to address patients' HRSNs in a coordinated way as long health care payer and provider organizations assist in providing start-up funds to build the required infrastructure and payer reimbursement is the foundation of the sustainability plan.

Exhibit 1

Community Care Hub Model



Source: Author's own figure

More detail on the CCH model can be found through the Partnership to Align Social Care here: Functions-of-a-Mature-Community-Care-Hub-May-2023.pdf (partnership2asc.org).

II. Support success in payer contracts via improved quality and cost: CMS stated an intention to move all Medicare and Medicaid beneficiaries into accountable care relationships by 2030.[10] The increased financial risk that health systems assume for those beneficiaries means that impacting health outcomes by addressing their HRSNs will become increasingly important to financial success.

III. Demonstrate community benefit: Approximately 58% of community health systems in the U.S. are nonprofit[11] and therefore must demonstrate community benefit to justify their tax-exempt status. Supporting start-up and ongoing efforts of a Community Care Hub via infrastructure and capacity building grants, service delivery grants for uninsured individuals, and staff planning contributions demonstrate a deep commitment to a shared community asset.

IV. Demonstrate commitment to equity: Through initiatives like the Healthcare Anchor Network (of which CommonSpirit Health and Trinity Health are both founding members), many health systems have started embedding equity into intentional hiring, purchasing, and investment strategies. CCHs are another opportunity to fulfill a commitment to health equity by investing in a long-term community infrastructure that is positioned to serve all populations, but especially those that experience the greatest barriers to achieving good health.

Conclusion

Health plans and health systems are increasingly motivated to systematically address the social factors affecting patients' health and are already developing infrastructure to screen patients and members for HRSNs to comply with federal and state regulatory and accreditation requirements. When it comes to providing social care services that resolve those HRSNs, there is no need for health systems to act on their own, outside their area of expertise. Evidence-based services and expertise often already exist in the community; all that is left is further building local community infrastructure to enable scaling of those community-based services that resolve patients' HRSNs. Health systems should strongly consider partnering with and supporting developing Community Care Hubs in their region to create a coordinated, sustainable network for meeting patient social needs. One way CommonSpirit Health and Trinity Health have done this is by actively participating in the national multi-sector collaborative, the Partnership to Align Social Care. More participation and representation from health systems in the Partnership to Align Social Care is welcome. To get involved, visit the website at www.partnership2asc.org.

Case Studies

Western New York Integrated Care Collaborative (WNYICC): The Western New York Integrated Care Collaborative (WNYICC) comprises more than 30 CBOs serving individuals of all ages in western and central New York and partners with healthcare plans and providers to improve patients' health. In 2020, WNYICC contracted with a regional Medicare Advantage plan to provide post-discharge home-delivered meals and incorporated patient satisfaction surveys to facilitate feedback to the health plan. After a successful proof-of-concept, their contract was expanded to include services including chronic care management, an expanded meal benefit, and a social isolation intervention. The model covers the entire western New York State region which includes diverse communities across a wide geography. The CCH model allows small, diverse CBOs to engage in robust contracting models by leveraging the centralized management infrastructure provided by WYNICC.

One of WNYICC's network members, Lifespan of Greater Rochester, implements a Community Care Connections (CCC) program that takes advantage of clinical encounters to link patients to resources that address health-related social needs. Providers make a referral to CCC when a patient is overusing medical care or struggling with a nonmedical issue. Case managers with Lifespan's CCC program follow up with assessments and link the patient to appropriate community-based services. With Lifespan acting as the hub in receiving referrals from physicians and home health, more than 1,200 CCC participants were connected to services between 2016 and 2019. Participants in the program experienced a 28 percent reduction in visits to the ED, a 29 percent reduction in inpatient hospitalizations, and a 23 percent reduction in observation stays in the 90 days after initiating program participation, compared to the 90 days before participation.

Mid-America Regional Council (MARC): MARC, the Area Agency on Aging of the greater Kansas City area, provides services to older adults and persons with disabilities in two states, nine counties, and 119 cities. MARC serves as the CCH for a network of CBOs addressing health-related social needs and the coordinated delivery of home and community-based services. MARC also operates a centralized referral management system to ensure that there is a streamlined process to conduct the interventions, support of bi-directional data exchange, and a closed-looped referral system with resource navigation services.

MARC now has a partnership with a prominent local health plan and their largest medical provider group, Spira Care Centers, to provide care transitions, evidence-based programs, and a community based care management intervention to high-risk members in its commercial plans and members enrolled in a new Medicare Advantage plan. These interventions were included in the Medicare Advantage (MA) plan benefits following a successful bid to CMS.

Note: the above case studies were written by the Partnership to Align Social Care and can be found in their document: Community Care Hubs: Making Social Care Happen.

Community Care HUB: Established in September 2020, the 1889 Jefferson Center for Population Health launched the Community Care HUB (CCH) for Cambria and Somerset Counties in Pennsylvania to primarily serve pregnant women on medical assistance or any woman with gestational diabetes, and expanded services during the pandemic to families identified in need within county school systems. In 2022, CCH successfully contracted with health plan partners to reimburse the Community Care HUB network for engaging residents and successfully addressing their needs.

Note: the above case studies were excerpted from Working with Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies written by Manatt Health in collaboration with the Partnership to Align Social Care 2022.

Works Cited

1 Hood CM, Gennuso KP, Swain GR, Catlin BB. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes. Am J Prev Med. 2016 Feb;50(2):129-35. doi: 10.1016/j.amepre.2015.08.024. Epub 2015 Oct 31. PMID: 26526164. County Health Rankings: Relationships Between Determinant Factors and Health Outcomes - PubMed (nih.gov)

2 Health Care Transformation Task Force I Introduction to Value & Social Determinants of Health (SDOH) (hcttf.org)

3 Centers for Medicare and Medicaid Services. The CMS Framework for Health Equity, 2022-2032. 2022. https://www.cms.gov/files/document/cms-framework-health-equity.pdf

4 FY 2023 health system Inpatient Prospective Payment System (IPPS) and Long-Term Care health system Prospective Payment System (LTCH PPS) Final Rule — CMS-1771-F. Centers for Medicare and Medicaid Services. August, 01, 2022. Accessed: https://www.cms.gov/newsroom/fact-sheets/fy-2023- health system-inpatient-prospective-payment-system-ipps-and-long-term-care-health system prospective

5 Medicare and Medicaid Programs: CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Continued Implementation of Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program," No. 2023-14624 (July 13, 2023): 236-273. Accessed: https://www.federalregister.gov/public-inspection/2023-14624/medicare-and-medicaid-programs-cy 2024-payment-policies-under-the-physician-fee-schedule-and-other

6 Kaiser Family Foundation. KFF Medicaid Waiver Tracker, June 23, 2023. https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section 1115-waivers-by-state/

7 Hinton, E., Guth, M., Raphael, J., Haldar, S., Rudowitz., R., Gifford, K., Lashbrook, A., Nardone, M., & Wimmer M. How the Pandemic Continues to Shape Medicaid Priorities : Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023. Health Management Associates. October 2022. https://files.kff.org/attachment/REPORT-How-the-Pandemic-Continues-to-Shape-Medicaid Priorities-Results-from-an-Annual-Medicaid-Budget-Survey-for-State-Fiscal-Years-2022-and-2023.pdf

8 Requirement, Rational, Reference: New Requirements to Reduce Health Care Disparities. The Joint Commission. Issue 36. June 20, 2022. Accessed: https://www.jointcommission.org/- /media/tjc/documents/standards/r3-reports/r3_disparities_july2022-6-20-2022.pdf

9 Reynolds, Andy. Social Need: New HEDIS Measure Uses Electronic Data to Look at Screening, Intervention. National Committee on Quality Assurance. Accessed: https://www.ncqa.org/blog/social need-new-hedis-measure-uses-electronic-data-to-look-at-screening-intervention/

10 Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade. Centers for Medicare and Medicaid Services. 2023. INNOVATION CENTER STRATEGY REFRESH (cms.gov)

11 American Hospital Association. Fast Facts on U.S. health systems, 2023. https://www.aha.org/statistics/fast-facts-us-health systems

About the Authors

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Marc Rosen is the System Director of Community Impact and Partnerships at CommonSpirit Health, a non-profit health system with care sites in 24 states. At CommonSpirit Health, he leads strategies that address the social needs of older adults through community-based partnerships. Through community based, vendor, and health system roles, Marc has spent the past 15 years working on clinic-to community partnerships focused on patient's chronic diseases and social needs. While in the SDoH vendor field, Marc led efforts to establish performance measurement frameworks for social care networks as well as efforts to evaluate the impact of those networks. His time in the community-based sector includes nearly seven years at YMCA of the USA, where as Director of Healthcare Integration he helped broker cross-sector partnerships that integrated Y's into care pathways and reimbursement models. Marc volunteers as a Spanish language medical interpreter at a free healthcare clinic in Chicago and holds a Bachelor of Arts from the University of Wisconsin-Madison in Latin American Studies and Spanish, and a Master of Public Health in Health Policy and Administration from the University of Illinois Chicago.

Maureen Pike, MPH MBA RN

Maureen Pike builds bridges between sectors and systematizes innovations to address the social determinants of health, with a special focus on serving people experiencing poverty and other vulnerabilities. She currently serves as the Director of Social and Clinical Care Integration at Trinity Health, a non-profit, multi-institution healthcare delivery system spanning 26 states. She began her career as a critical care nurse and has since led work on health policy, healthcare-community partnerships, disease prevention programming, health care access, value-based care, and social care integration at a variety of organizations across local, state, and national levels. Maureen received a BS in Nursing from Kent State University, Master of Public Health from the Johns Hopkins Bloomberg School of Public Health, and a Master of Business Administration from the Kellogg School of Management at Northwestern University.

Partnership to Align Community Care

The Partnership to Align Community Care ("Partnership") is a learning, sharing, and change collaborative whose purpose is to advance and scale sustainable and aligned health and community care delivery systems through cross-sector collaboration leveraging Community Care Hubs (CCHs) to promote whole-person health. 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. Partnership stakeholders collectively advance initiatives that build awareness about the role of CCHs in addressing upstream drivers of health, expand clinical integration by strengthening billing and coding pathways to better support CCH-delivered services, and create resources to elevate innovative practices and mitigate challenges for health care entities, community organizations, and community care providers pursing cost-effective, high-quality care.

For more information about the Partnership to Align Community Care, visit **www.partnership2acc.org**.