Welcome!

Enter into the chat:

1) Name, organization, and …

2) What comes to mind when you hear the term

'Community Hub?'

Greater Health Now

Greater Health Now

- Greater Health Now, established in 2015 is one of 9 regional Accountable Communities of Health(ACH) funded by the Center for Medicaid Services (CMS) through the WA State Health Care Authority (HCA). Each ACH is an independent 501C3 organization, not a state agency.
- ACHs were established under the CMS Medicaid Transformation Project to develop innovative strategies to increase population health outcomes.
- Greater Health Now is the largest ACH in the State of WA by territory, serving 9 counties throughout Southeast WA, and the third largest in the state by Medicaid lives served.
- 1. Healthier Here (Seattle area) 2. North Sound ACH at 15%. 3. Greater Health Now at 14%

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MTP 2.0: Terminology and Acronyms

Health Related Social Needs (HRSN)

- *An individual's unmet, adverse social needs that contribute to poor health resulting from their community's underlying SDOH.*

Community Based Care Coordination (CBCC)

- *Locally based supports for individuals and families across the continuum of care that reduces fragmentation, improves access, and meets HRSN needs.*

Community Hub

- *A community-centered entity that organizes and supports a network of contracted case management agencies*

"Case Management"

- *Refers to designated activities for the purpose of assessing and supporting a client's HRSN needs. Often used interchangeably with care coordination, navigation, and care management*

Bird's Eye View: MTP 2.0

Accelerating care delivery and payment innovation focused on health-related social needs (HRSNs) and equity through:

- *Community based care coordination hubs – aka "Community Hub"*
- *Community-based workforce*
- *Statewide Tribal Hub (HCA)*
- *Re-entry for short-term pre and post release services from corrections settings (TBD)*
- *Health Equity programs (TBD)*

MTP 2.0: What it Is and is Not

What it IS

An opportunity to partner with Greater Health Now to:

- Deliver CBCC services through the Community Hub
- Build capacity/infrastructure for providing CBCC
- Receive workforce support through FTE funding, training/TA, and infrastructure investment
- Contribute to and partner with a network of Hub case management partners
- Serve community members through case management
- Integrate into a Client Management System (CMS)

What it's NOT

Unrestricted, flexible funding to:

- Sustain current care coordination and case management programs that are NOT part of the Community Hub
- Resource community/clinical innovation projects
- Support integrated care efforts
- Initiate workforce or career pipeline programs (unrelated to Community Hub)
- Implement population health management tools

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Key Differences Between MTP 1.0 and 2.0

MTP 1.0

- Flexible.
- Broad scope.
- ACHs had broad autonomy to choose projects and approaches, and how to invest the MTP 1.0 funds.
- Greater Health Now largely provided flexible funds for partners to invest in capacity building and developing infrastructure with minimal oversight.
- Deliverable based contracts.

MTP 2.0

- More prescribed, less flexible.
- Narrower focus.
- Specific role for ACHs- to be a Community Hub and deliver case management and HRSN services to the community.
- Hub funding will support capacity building for Hub Case Management partners and reimbursement for services provided by contracted HRSN benefits providers.
- Contracts for service delivery.

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Why Community-Based Care Coordination?

- During the first 5 years of the MTP waiver, HCA identified community-based care coordination (CBCC) as a significant strategy for improving the health of Medicaid enrollees.

- Throughout MTP 1.0, CBCC also emerged as an area of high potential for ACHs to have actionable impact, particularly with the positionality to:

  - *Be a neutral convener*
  - *Build trusted relationships with regional partners*
  - *Steward regional funding*
  - *Provide training, TA, and QI support*

- In MTP 2.0 ACHs have a specific role- to serve as Community Hubs for community-based care coordination and delivery of Health-Related Social Needs (HRSN) services.

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How Will this Benefit Our Communities?

- Through CBCC services and HRSNs, the Community Hub will help individuals and families in our South Central Region more easily connect to supports and resources to achieve their optimal health and wellbeing
- Improved navigation of the health and social services systems
- Access to culturally responsive services for communities by people in their communities
- Improved coordination across sectors
- Improved advocacy for resource and access needs through the availability of robust data
- Large scale community-based workforce support

What about GHN as a Community Hub?

Under MTP 2.0, a Community Hub is a community-centered entity that **ORGANIZES** and **SUPPORTS** a network of **HUB CASE MANAGEMENT PARTNERS** providing

1) Case management services and
2) Connecting people to health-related social needs services

A Hub Centralizes Administrative and Operational Functions/Infrastructure Including:

- Contracting with case management partners
- Payment operations
- Managing and assigning referrals
- Service delivery compliance
- Technology infrastructure
- Information security
- Data collection & reporting
- Training/TA/QI support

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Forms and Supports a Network of Case Management Partners

- Community-based, Tribal led/serving, and clinical organizations
- Agencies receive referrals to provide case management services
- Honors & leverages the capacity of local organizations to provide culturally responsive services to community through a reflective workforce
- Fosters cross-sector collaboration across a network of agencies

It is the Centralized Place of Coordination for Referral to Community-Based Resources

- Central (not single) point of referral
- Role is to connect, coordinate, and collaborate on behalf of people who need support (outside clinical care)
- Provide warm handoff to connect people to clinical care when needed (in partnership with MCOs for their Medicaid enrollees)

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Greater Health Now's Community Hub

It is **EQUITY CENTERED**

Will **SERVE THE WHOLE COMMUNITY** through case management services (not just the Medicaid population)

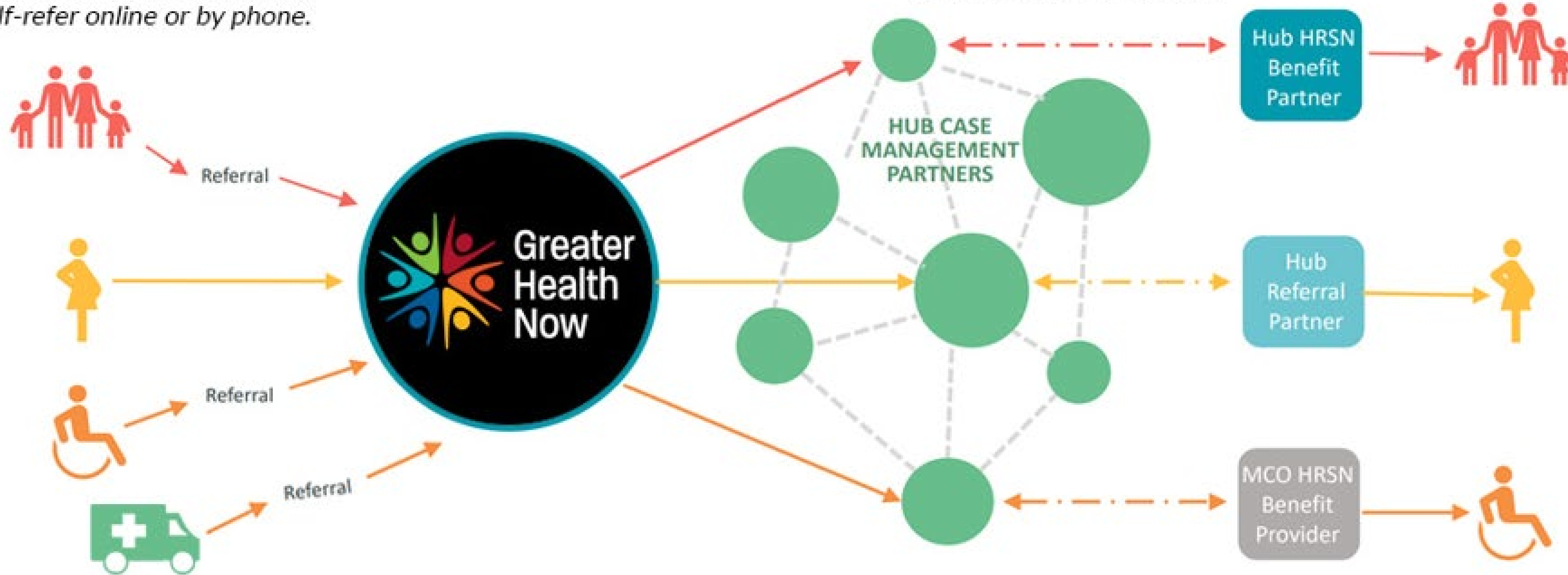
- Many communities aren't Medicaid eligible but still have a need for case management.
- People cycle on and off Medicaid.
- A 'no wrong door' approach is consistent with GHN values.

A Visual Representation of the Community Hub

Clients are referred to the Greater Health Now Hub by a CBO, Health Care Provider or Social Service Agency or may self-refer online or by phone.

Clients ore screened and referred to a HUB Case Management Partner based on cultural/ language match.

The Case Manager assesses the clients' needs and available benefits and connects them to Health Related Social Needs (HRSN) providers, then follows up to assure their needs are met.



What We Still Don't Know

- **Contract details!** *(Special terms and conditions, protocols, payment methodology)*
- Which HRSNs will be approved and for which specific populations (Probably will be a phased approach)
- Mechanisms by which case managers and/or the Hub can verify clinical indication for HRSNs
- How Greater Health Now will be able to resource organizations for infrastructure needed to participate as a Hub Case Management partner
- Reimbursement for Hub Case Management partner contracts
- How the re-entry program will be structured and administered (2025)

Questions?