The National Summit on Health Care and Social Service Integration: Foundational Efforts and Rationale for Integrating Health Care and Social Services

Introduction

Health care providers, payers, and systems are increasingly interested in approaches that address both medical needs and social determinants of health (SDOH). The need to reduce health care utilization while improving quality of life, as well as promoting the self-management of chronic health conditions is more important than ever as the health care sector transitions to value-based payment models. Integration of care allows for the provision of services delivered in the home and in the community that prevent falls, address food insecurity and transportation issues, manage chronic disease, support employment and economic independence, reduce social isolation, and address other non-clinical risk factors. These essential services are shown to **improve health outcomes and reduce the cost of care**. This is particularly true for "**high-need, high-cost**" people who have complex health conditions and social risk factors and who often have significant functional limitations. Moreover, care planning for such individuals can become heavily medicalized, at the expense of more individualized, person-centered planning.

Integrating these services into health care delivery requires robust planning and assessment, expert knowledge of how to navigate complicated social service systems, ongoing case management, and accountability for service delivery and outcomes. It also requires health care payers and providers either to "build" internal organizational capacity or to "buy" additional capacity from existing service providers. When making that decision, there are many factors for health care organizations to take into consideration, not the least of which are local factors in the communities and markets they serve. In other words, integrating SDOH into traditional health care is a sizeable undertaking. For many organizations, partnering with existing networks of community-based organizations is a more cost-effective strategy for providing quality services and supports.

To succeed, plans for integration must draw on the expertise of stakeholders across the nation. These stakeholders include community-based organizations (CBOs) and their networks; state agencies (e.g. aging, mental health, intellectual/developmental disabilities); national associations; federal agencies, especially those within the U.S. Department of Health and

Human Services (HHS); health plans and health systems; and experts in SDOH financing and health information technology (IT).

Starting in the fall of 2019, the Administration for Community Living (ACL), an operating division of HHS, undertook a series of activities to engage these stakeholders in conversations on how to grow and strengthen the network of CBOs that provide integrated health services addressing both medical needs and SDOH. As of the spring of 2020, those activities include:

1. Interviews with key informants in October and November of 2019.
2. A small roundtable of approximately 25 CBO stakeholders convened in Washington, DC, on December 5, 2019.
3. Semi-monthly conference calls and presentations with a workgroup comprised of select participants in the December roundtable.
4. A national Summit convened in Washington, DC on March 4, 2020, attended by more than 150 participants representing organizations ranging across federal and state staff, thought leaders, CBO network experts, health plan and health system decision-makers, and national associations and foundations representing these organizations and the aging and disability community.

This report begins by reviewing these activities and then synthesizing their outcomes into a model for how CBOs and their network partners can transform themselves into community-integrated health networks (CIHNs) by addressing issues of financing, data and technology, governance, and scaling up from the local, state, and regional levels to a national-level CIHN.

Understanding the Challenges Associated with Integrated Health and Social Services

Key Informant Interviews

ACL recognizes the value of the aging and disability network, particularly community-based organizations (CBOs), as integral to the integration of health and social care. When networks of CBOs act in partnership with providers, payers, and health systems, the resulting integrated system can lead to better outcomes and lower costs. Networks will be especially effective if they emphasize values of trust, shared leadership, accountability, sustainability, and innovation.

In October 2019, ACL conducted interviews with stakeholders with expertise in business acumen among CBOs and CBO networks that provide long-term services and supports (LTSS). ACL conducted these interviews to gain an understanding of how these individuals in the field view the present state of service delivery and their expectations for the future. The interviews elicited expert opinion on the business acumen needs and priorities of CBOs and CBO networks; the role of state agencies and CBOs serving older adults and individuals with disabilities and

their families; and state-level promising practices related to business acumen. Two main themes emerged from these discussions: (1) the need to address siloed services, and (2) the need to clarify the gaps and strengths of CBOs.

In December 2019, ACL held focus group discussions with state and health plan leaders, including participants of an SDOH-related learning collaborative convened by America's Health Insurance Plans (AHIP). Participants reached a consensus that establishing a strong network lead entity (NLE) – an organization that acts as a single point of accountability for health care organizations — could help CBOs standardize practices, execute effective contracts with health care organizations, and develop capacity. Additionally, there was agreement that, to move toward scaling CBO networks, an established method of electronic data exchange is necessary. Finally, the leaders agreed that, while buy-in from state system leaders is important, education, culture change, and buy-in across the local level are essential.

Table 1 provides a summary of the stakeholders and a brief biographical sketch.

Table 1. Interviewees and Focus Group Members

Name	Date	Description
Tim McNeill, Freedmen's Health, LLC, Health Care Consultant	10/18/2019	Mr. McNeill specializes in health program development and sustainability. He has worked with many federal level clients, including the U.S. Department of Health and Human Services (HHS), U.S. Administration on Aging (AoA), and ACL, as well as state level leaders, CBO leaders, and health system and plan executives in his career.
Kevin Moore, Vice President of Policy, Health, and Human Services at UnitedHealth Group	10/30/2019	Prior to joining UnitedHealth Group, Mr. Moore was the Senior Vice President of Medicaid Strategy for Aurora Health Care and the Medicaid Director for Wisconsin's Department of Health Services. He has over 16 years of experience in LTSS, managed care, Medicaid, public health, and clinical health care for individuals with disabilities. Mr. Moore specializes in the development of sustainable interventions that improve community health by identifying and addressing social, economic, workforce, transportation, and nutritional barriers.

Name	Date	Description
Jacob Reider, CEO of Alliance for Better Health	10/23/2019	Dr. Reider is a family physician with more than 30 years of experience in health policy and health IT, with a special interest in user experience, clinical decision support, and information portability. He currently serves as CEO of Alliance for Better Health, a New York Delivery System Reform Incentive Payment (DSRIP) program care transformation initiative, and as adviser and board member for several private sector organizations focused on health and health care.
Focus Group with State Leaders, ADvancing States leadership	12/10/2019	This focus group convened state leaders and representatives from ADvancing States to discuss the role that state leaders have in addressing SDOH and fostering networks of CBOs. Participating state leaders came from Alabama, Alaska, Florida, New York, and Virginia.
Focus Group with America's Health Insurance Plans (AHIP) Project Link Learning Collaborative	12/11/2019	This focus group call provided ACL the opportunity to listen to participants in AHIP's Project Link Learning Collaborative on partnering with CBOs to provide services to address the needs of older adults and individuals with disabilities. Participating health plans included Kaiser Permanente, UCare, SCAN Health Plan, Highmark Health, Fallon Health, and AmeriHealth.

The information gleaned from each of these discussions helped identify promising practices, as well as the opportunities and challenges inherent in CBO partnership with health plans and systems.

- Mr. McNeill discussed the importance of a single point of accountability, or NLE, while scaling CBO networks, and the role of supplemental benefits in terms of market competition.
- Mr. Moore helped conceptualize an efficient and high performing value-based payment model. He supported ACL's prioritization of SDOH, avoiding siloed systems and the medicalization of CBOs, and the role of Medicaid expansion policies.
- Dr. Reider provided insights into how health care providers view the challenges and opportunities for integrated care partnerships.
- The ADvancing States focus group shared promising practices on how to move toward a person-centered, value-based payment model. They emphasized the role of education, culture-change, and buy-in of stakeholders across all levels.
- AHIP Focus Group discussed the benefit of having formalized partnerships between CBOs and health care plans as well as the role of established electronic data exchange.

The discussions both informed ACL's thinking and led to the formation of the deliverables outlined in this paper, as well as the development of the CBO Roundtable and Summit agendas.

Enhancing Community-Based Networks for Nationwide Capacity Roundtable

The Enhancing Community-Based Networks for Nationwide Capacity Roundtable was hosted in Washington, DC, on December 5, 2019. Attendees came from the aging and independent living community, as well as national organizations, institutes, and associations interested in the integration of care more broadly, including:

- Representatives of the aging and independent living communities.
- Senior leadership at Area Agencies on Aging (AAA) and Aging and Disability Resource Centers (ADRCs).
- Senior leadership at national organizations specializing in quality.
- Senior leadership at institutes that support business development among CBO networks.
- Senior leadership at foundations that specialize in grant making to support innovative community LTSS programs.
- Senior leadership at foundations, nonprofits, and institutes that support the spread of services that address SDOH by promoting research, promulgating best practices, and awarding grants.
- Consultants specializing in service financing, health IT, and interoperability.

A full list of attendees is found in **Appendix A**.

Roundtable participants learned of ACL's core aims to develop business acumen among CBO networks and proposed efforts to help CBOs scale from the local level to the state, regional, or national levels. Participants also learned of and provided feedback on ACL's suggestions for what networks might look like and how they might partner with health plans and health systems. ACL's suggestions were supported by presentations of CBO network developers and contractors who have supported similar efforts.

The group discussed the following topics:

- How health plans and systems might invest in CBO network development, and whether they should be considered formal members of those networks or as purchasers of the services that those networks offer.
- The key role that the direct care workforce plays in ensuring that the demand for services can be met.
- The importance of recognizing that some CBOs are more ready than others to assume the role of a network lead entity.
- How to promote collaboration among neighboring lead entities.

- How emerging networks might deepen their expertise in health IT and data analytics by joining with partners that already have the necessary expertise.
- Ways to minimize the administrative burdens that a hub-and-spoke model might create.
- Strategies for partnering with Medicaid managed care organizations (MCOs) and Medicare Advantage as key purchasers of network services, especially by using pay-for-performance financing models that can make purchasing services more attractive to potential buyers.
- The importance of adopting evidence-based practices that are also person-centered.

Following the group discussion, participants divided into break out groups to discuss two topics: (1) payment and financing and (2) technology. Breakouts were facilitated by identified leaders in the field – Tim McNeill for payment and financing and Dr. Reider for technology. **Table 2** provides more information on the main discussion points of these breakout sessions.

Table 2. Roundtable Breakout Groups

Breakout Session	Main Discussion Points
Finance	• The need to support CBOs (and health plans and payers) to determine how to price network services • The need to support CBOs in demonstrating strong return on investment (ROI) to purchasers • The need to educate prospective purchasers, especially hospitals, about the impact of SDOH on outcomes (for example, by reducing rates of re-hospitalization, for which hospitals are typically penalized) • The importance of securing a "place at the table" early in discussions between states and MCOs, well before a state opts to issues a request for proposals (RFP) for MCOs, when it is still possible to make the case that MCOs should be required to purchase such services

Breakout Session	Main Discussion Points
Technology	• The power of technology platforms to promote closed loop solutions, from referral to service delivery to outcome assessment • Fragmentation of health IT systems, including those built by large health systems, and those created by vendors that sell to large health systems, which often creates an inability to interoperate and thus propagates "walled gardens" of data • Challenges in moving any system, or set of interoperable systems, to a national scale without a large-scale federal push that comes with funding • The role that HIPAA – and data security and privacy more broadly – must play in CBO use of health IT platforms. It may be useful to develop a privacy and security standardization toolkit geared specifically to CBOs.

The day ended with a "call to action" from Roundtable participants to continue the conversation – and support ACL in identifying appropriate next steps and structures required to scale integrated networks nationally.

Roundtable Workgroup

A subset of Roundtable participants, listed in **Appendix A**, agreed to meet twice a month to discuss key issues that arose during the Roundtable. The composition of the Roundtable Workgroup broadly resembled the composition of the Roundtable itself. Several members led CBOs and CBO networks, two were leaders of a prominent non-profit, and two represented a national association.

The Workgroup had four immediate goals:

1. Increase situational awareness of CBO-led network activity and development.
2. Clarify the roles and responsibilities of CBO-led networks.
3. Identify and discuss potential strategies and tactics to reach nationwide coverage.
4. Develop communication protocols for how to describe CBO networks.

Between January and March 2020, the group met regularly five times. Over the course of its five meetings and the weeks between, the Workgroup:

- Supplied details about existing networks, including their names, locations, network leads, and geographic scope (local, statewide, etc.).
- Discussed the range of challenges in coordinating community LTSS that CBO networks might solve.

- Decided on a name for such networks: community-integrated health networks (CIHNs).
- Decided on a name for the lead organization in such networks: network lead entity (NLE).
- Identified the five attributes that comprise the value proposition of a network (detailed below).
- Discussed the set of core services that CIHNs should offer or coordinate, including assessments, information and referral, medication management, nutritional assistance, transportation assistance, and personal care and chore services.
- Provided feedback on several drafts of a paper to be distributed as pre-reading to those attending the National Summit on Health Care and Social Service Integration in March.
- Discussed emerging network needs connected to the COVID-19 pandemic. Concerns regarding the pandemic were the importance of flexible service delivery, avenues of communicating with other CBOs that may be experiencing similar shortages and needs, and securing additional funding. Nutrition services, social isolation, and childcare were the areas most impacted by COVID-19, with many CBOs experiencing severe shortages in the workforce needing to address these issues.

The Workgroup identified the following five attributes as central to the value proposition of a CIHN:

1. **Trust**: Networks leverage existing relationships in the community to ensure that individuals feel understood and supported.
2. **Leadership**: Social service and health care decision-makers share leadership responsibilities in planning and managing social assessments, referrals, service delivery, and team-based, holistic care.
3. **Accountability**: Social service leaders implement a system of accountability and quality improvement at all levels using agreed-upon performance benchmarks, frameworks for regular reporting, and data-driven strategies for improvement.
4. **Sustainability**: Networks finance services that address SDOH through multi-payer arrangements that build community capacity. Over time, they transition from a fee-for-service payment model to value-based/risk-based payment models for delivering social services in comprehensive, coordinated care environments.
5. **Innovation**: To maximize efficient delivery of services and health outcomes, networks implement, evaluate, and iterate evidence-based interventions and innovative care models.

The paper the Workgroup helped ACL draft in advance of the Summit, included in **Appendix B**, consisted of a preamble containing the attributes described above; a review of the evidence showing that, by addressing SDOH, CIHNs improve medical outcomes and lower costs; a

discussion of how CIHNs could be organized with an NLE; and a review of the common services that CIHNs might coordinate or provide.

National Summit on Health Care and Social Service Integration

The National Summit on Health Care and Social Service Integration took place on March 5, 2020 in Washington, DC. More than 150 people attended. Participants were affiliated with federal agencies, state agencies, health plans, health systems, national associations, AAAs, Centers for Independent Living (CILs), universities, philanthropy, advocacy groups, and more.

The Summit's main goals were to develop a shared approach for integrating medical and social care, highlight integrated models that have demonstrated significant success for older adults and people with disabilities, and develop strategies for effective CBO-health care partnerships. To achieve these goals, ACL requested support from both federal and private entity partners to present and facilitate discussion. The Summit focused on ACL's vision for better outcomes and lower costs through community partnerships, which includes community integrated health networks that collectively build nationwide capacity to deliver services through multi-payer financing models and shared technology platforms. The Summit also highlighted the current state of health care and social services integration. To help align participant interests and next steps, ACL elicited feedback from participants on a set of shared goals and principles to frame a person-centered approach to integrate health care and social services. The attendees envisioned the structure of CBOs to move toward a tiered model founded in shared leadership responsibility between social service and health care decision makers. Attendees agreed that CBO networks could be built at local, regional, and statewide levels, and establishing strong NLEs would ensure quality, standardization, and enforcement of adequate contracting across the CBO networks.

The day continued with discussing key opportunities for States and ended in a series of breakout sessions to allow for both networking and further discussion on the topics of financing social care; scaling networks of CBOs; technology enablers and barriers; and the role of federal and state governments.

Each session of the Summit allowed both presenters and participants to identify opportunities and actions to take to support this national effort. Highlights from each session are outlined in **Appendix C**.

Developing Community Integrated Health Networks

Throughout all efforts, ACL explored the current system and identified gaps and barriers to achieving an integrated health and social service system. These activities allowed ACL and all stakeholders to draw upon shared expertise. Through this engagement with stakeholders, ACL determined ways that CBOs and their network partners can transform into CIHNs by addressing

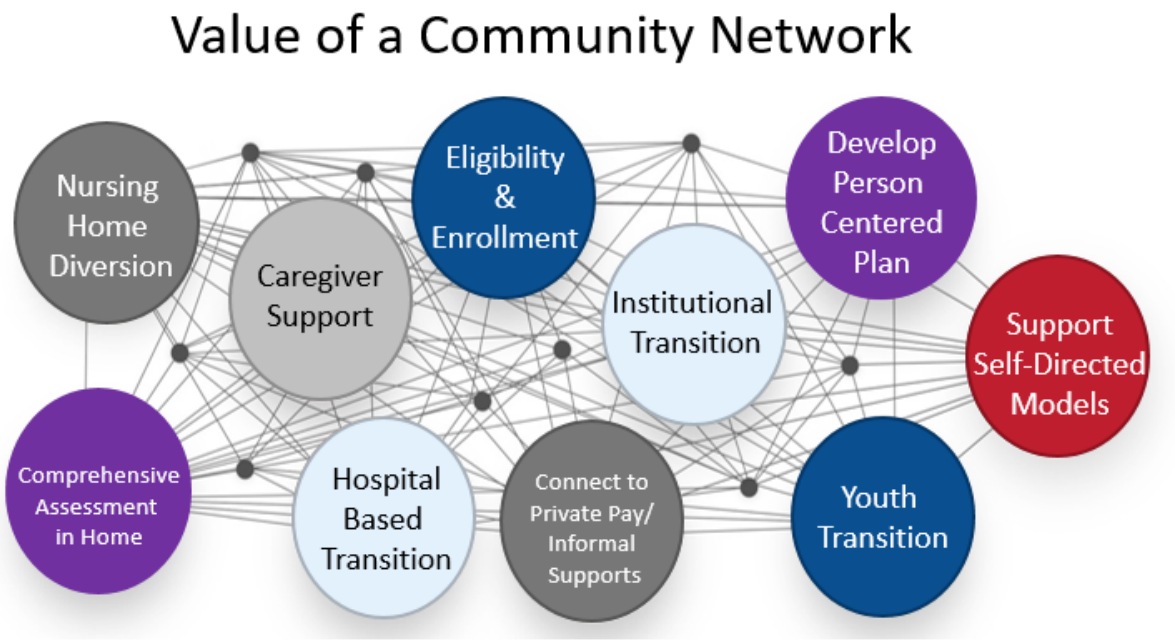
issues of financing, data and technology, governance, and scaling up from the local, state, and regional levels to a national level of CIHNs. Shared understanding of the value of CIHNs is paramount to this work.

Value of Community Integrated Health Networks

Integrating social services with health care is critical to effectively addressing SDOH. Anecdotal evidence from existing CBO and health plan and/or system partnerships reflect the value of network development. CBOs that form networks in the community can more easily contract with larger health plans and health systems to bring social service delivery systems into the health care marketplace. As organizations established in the community that clients already trust, CBOs can facilitate the various health and social care services available to individuals as they live in their communities among family and friends or, following admission to a nursing home, they transition back to their communities These transition services will, in turn, streamline the care an individual receives, leading to lower overall costs and a decreased likelihood of readmission to the hospital. **Figure 1** shows how CIHNs can integrate care across the myriad LTSS that individuals need to navigate to address SDOH.

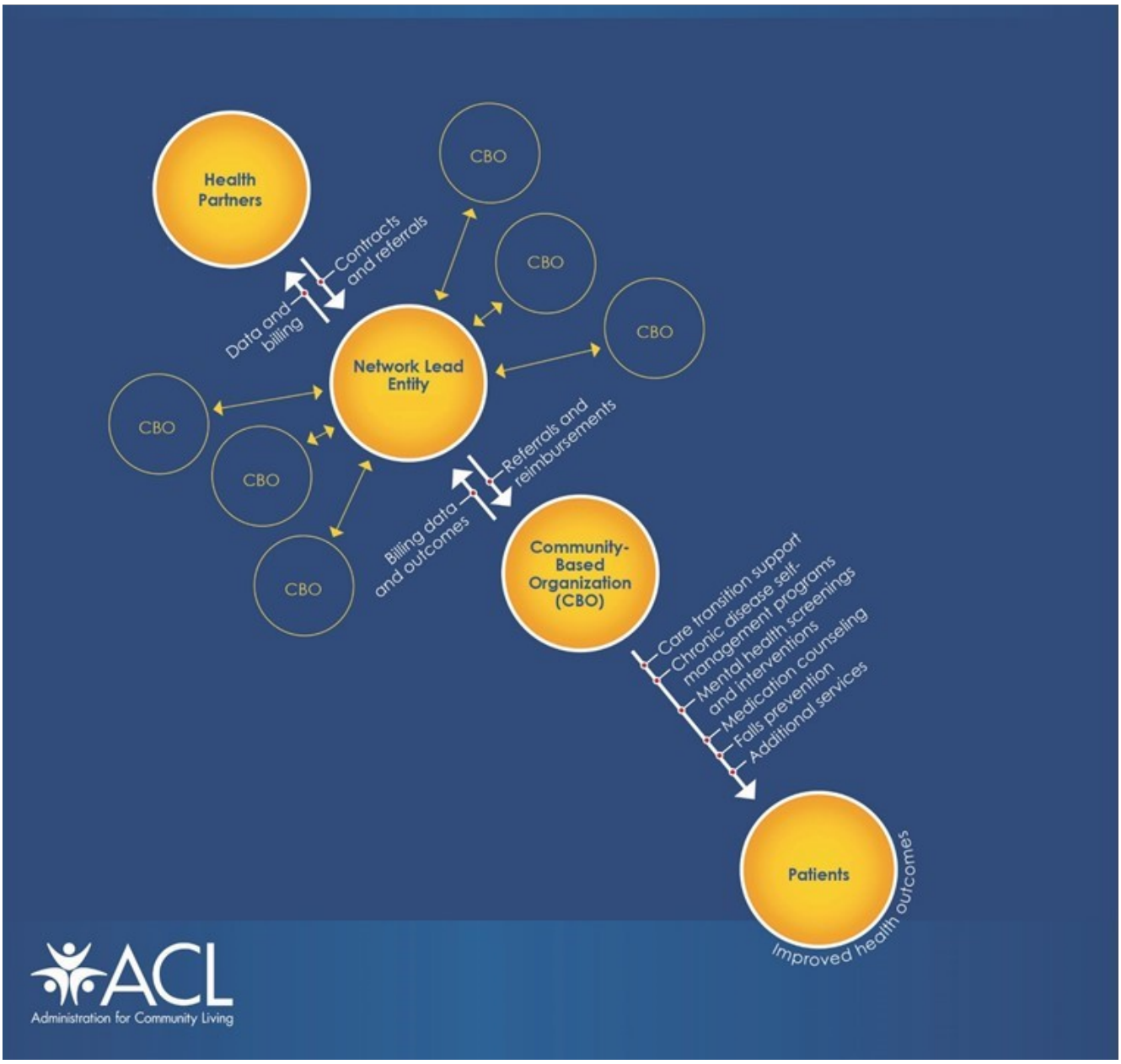
> **CIHNs** are coordinated groups of visible and trusted CBOs that have entered into a formal partnership with health care organizations with the goal of integrating health care and social services.

Figure 1. Value of a Community Network



These networks, known as CIHNs, reflect collaboration between health care organization and social service networks **and are associated with higher performance and reduced health care costs**. CIHNs are led by a NLE, an organization that assumes responsibility for directing the development and design of a network structure, facilitates services, and provides administrative oversight and governance. A significant advantage of NLE-led CIHNs is their capacity to provide services at different geographic levels to meet the market demand of health plans' and systems' geographic footprint, such as (1) community-wide; (2) statewide; (3) regionally across state lines; and (4) nationally across multiple states. **Figure 2** shows how an NLE can coordinate CBOs within the CIHN to work with health systems and health plans to integrate social services for patients.

Figure 2. Potential CIHN Structure



While the development of CIHNs requires robust planning, coordinated efforts to align services, and strong commitment from participating entities, the benefits of these networks and the formal partnerships with health care organizations are numerous. Studies indicate that the integration of social services and health care can lead to **lower costs, lower hospitalization rates, and improved outcomes for patients.**

Alongside financial and value-based metrics, such as those outlined in the **case study on VAAACares®**, CIHNs improve health and social system by offering the following:

- A broader array of social services through partnerships.
- The potential to reach a greater number of the population in need through a broader geographic reach into the community.
- The opportunity to serve as a one-stop coordinated system to link consumers to whichever services they may need.
- The development of a stronger administrative infrastructure for delivering SDOH services.
- The potential to offer positive impact at economies of scale.
- The chance to improve overall care management for individuals.
- The chance to capitalize on a unique position to partner with health systems and health plans to establish and promote deeper collaborative efforts.[1]

CIHNs Successes: [1]

VAAACares,® a statewide one-stop coalition providing care coordination, care transitions, and other services, reduced the 30-day readmission rate from 18.2% to 8.9% through their partnership with four health systems, 69 skilled nursing facilities, and 3 health plans.

Elder Services of the Merrimack Valley, a AAA in northeast Massachusetts, and their network of community partners have shown an 11% reduction in total cost of care through their collaboration with health care organizations.

The Veterans Health Administration, through the Veteran Directed Care program, has had purchasing agreements over the last decade with CBO network organizations across 37 states to provide nursing-home-eligible veterans with a counselor and a monthly budget to obtain the long-term services and supports they need to live in the community—at about one-third of the cost of a nursing home.

Strong, established CIHNs have unique positions in their diverse communities. With strategic partnerships with health plans and systems, CIHNs bring integrated care to the individuals in their communities.

Key Challenges for CIHNs

The work that ACL undertakes is designed to further understand and address key challenges and opportunities that CIHNs currently face as they gradually develop broader partnerships. Four key domains for integrating health and social care require focused attention and collaboration:

1. Financing Social Care

2. Data and Technology Interoperability
3. Governance and State Leadership
4. Scaling

The sections that follow will discuss each of these domains in turn.

Financing Social Care

As organizations think about how to finance social care, it is crucial to understand how to establish a shared payment model to support the integration of social and medical care. There are various ways to do this, but a multi-payer system is likely the most feasible model for funding social service delivery effectively to ensure the sustainability of the networks. A multi-payer system engages multiple payer sources to support the collective business goal of integrating the social and medical care services into one network. Multi-payer systems work together to identify and define how to best support the payment of comprehensive social service and medical costs by blending services and payments. Other multi-payer systems engage different payers for scaled services across multiple payers to support the provision of services to individuals in need within the community.

Challenges with financing social care services consistently arise when it comes to billing. Stakeholders engaged in the aforementioned interviews noted that there is frequently a mismatch in the language used to describe services, and that mismatch impacts how organizations perceive billing to Medicaid. There is an opportunity to better align language in contract development and writing with the perspectives of CIHNs and the ideal multi-payer system partners. Unfortunately, CBOs are often not at the table when initial discussions of Medicaid or Medicare contracts occur, when there would be an opportunity to align billing codes for social services across systems. At the state level, when waivers and waiver programs are being developed or operationalized, agreements with health plans are implemented two to three years before a Request for Proposals is released. This usually leaves CBOs out of the loop and misses an opportunity to ensure CBOs can provide the essential input and prepare waiver processes from the start of implementation.

CBOs must understand the value of attending public events and providing public comments to share their perspectives on how alignment between systems can promote further integration between social and health care services. National associations and organizations, such as n4a, can provide educational opportunities to CBOs and encourage them to take a seat at the table when initial conversations are held. Including CBOs in contract discussions can lead to contract language that is clear and concise and that enhances the integration of health and social services to the benefit of people in need. Stakeholders and leaders should encourage CBOs to contribute to the national transition to an integrated system. The integration of traditionally

siloed organizations can strengthen relationships with legislators and with providers at every level of the system.

For instance, partnerships between CIHNs and Medicare Advantage plans can promote service innovation. CIHNs can identify individuals with specific health conditions or social risk factors and address needs left unmet by medical providers. Additionally, CIHNs can persuade additional payer-partners to work with them. If CIHNs participate in early Medicare Advantage conversations held among the state, health systems, and health plans, they could learn how to design programs and services that allow CIHNs to strengthen the whole service delivery. This would promote service integration in the initial stages of program development and thus require less effort to make revisions or clarifications later.

Data and Technology Interoperability

Self-sustaining CIHNs depend on data technology to support the successful integration of social services and health care. If data are not shared, services will not be delivered efficiently and effectively to those who need it. Poor service coordination can leave individuals in need at increased risk of poor health outcomes.

A lack of system interoperability and data sharing represent the **largest technological barrier** to integrating social services and health care. The problems that follow are exacerbated by:

What is interoperability?

According to Health Information Management Society System (HIMSS), **interoperability** is the ability of different information systems, devices, and applications (or "systems") to access, exchange, integrate, and cooperatively use data in a coordinated manner, within and across organizational, regional, and national boundaries, to provide timely and seamless portability of information, and optimize the health of individuals and populations globally.

- Difficulties navigating and aligning legal requirements, state-specific regulations, and data sharing policies and procedures across partners.
- Data infrastructure capabilities.
- Inconsistent definitions of data elements and technical specifications.
- Frequent updates to technological platforms.
- Lack of sufficient training.
- Competitor dynamics.
- The need to change existing processes to allow for data sharing.

Furthermore, less robust technological systems can lead to billing issues, as well as impede quality measurement, performance monitoring, and real-time refinements of care plans and service delivery.

The success of integrated health and social care solutions depends crucially on interoperability. It promotes improvements in information sharing across the entire CIHN and its health partners; allows access to accurate, up-to-date information at the right time to support informed and person-centered care; and reduces burdens on providers and CBOs trying to promote a holistic care delivery system. As efforts to promote CIHNs and partnerships between CBOs and health care organizations advance, it will be critical to establish procedures to share data and support interoperable systems that work for both health care and social service systems. Key elements to consider when establishing the infrastructure for integrated care include closed loop referrals, data standards, governance, policy, informed consent, and privacy.

Typically, exchanging data between providers and CBOs requires complex systems that can communicate between CBOs in the CIHN, as well as partner health systems and health plans. CIHNs must have systems capable of receiving electronic information as well as transmitting information to payers. However, since CIHNs are actively forming and developing broader networks, there is an opportunity to streamline and create a data system platform that works for both parties from the onset.

There are many opportunities to build the necessary interoperable infrastructure and ensure that all partners can communicate electronically. Technological infrastructure development should focus on ensuring coordinated language amongst partners, aligned financial incentives, shared interpretations of provider laws, and trust between partners and the individuals they serve. Federal agencies, such as Office of the National Coordinator (ONC), working with the Centers for Medicare and Medicaid Services' Center for Medicare and Medicaid Innovation (CMS CMMI), can support these efforts by establishing standardized guidance on what data is collected and what standards to apply. Guidance could focus on existing technical standards (e.g., HL7 and IEEE) that minimize technological complexity. State leaders, executives from health systems and health plans, and community leaders should support efforts to standardize terminology, data structures, and definitions for data platforms.

Governance and State Leadership

To manage ongoing activities and promote expansion, CIHNs require strong leadership by a governing body. A governing body is a partnership between a variety of entities involved in the delivery of health and social services. The governing body oversees and organizes the CIHN; gathers and incorporates input from stakeholders; and guides the network toward a streamlined, person-centered, accessible, and cost-effective technological infrastructure. Governance should establish a clear mission to drive the work of all stakeholders.

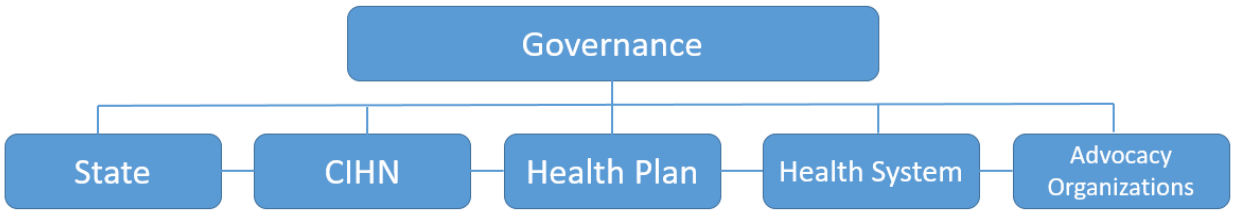
Robust governance from the beginning can improve chances of success in scaling, financing, and data sharing. Stakeholders from all levels, including NLEs, community leaders, state and

regional leaders, health system and health plan executives, and federal support, should participate in governance activities. Federal agencies (including ACL and CMS), state agencies (including the State Unit on Aging [SUA] and Medicaid Agency), aging and disability organizations, and health plans and health systems all play a role in the development and acceleration of integrated health and social care. There is an opportunity for all stakeholders to get involved, foster relationships and partnerships, and support the development of strong CIHNs.

Stage agencies – especially SUAs — can convene these meetings and facilitate conversations among partners by bringing the broader perspective of the state, while health plans, health systems, and CBO leaders understand exactly what services are needed and how they can build an effective partnership. As the convener, the state can influence policies that support the integration of health care and social services. More specifically, states can foster relationships between the state's Medicaid Agency, CBOs, CIHN leaders, health plans, and health systems and opportunities from organizations outside of the state. It is important to focus on how the state's work aligns with the work of other agencies and how to champion the network throughout the state. 17

For CIHNs to develop and establish successful partnerships with health systems and plans, they must identify a workable way to handle governance from the outset. Due to their unique position, states play an instrumental role in establishing a governance structure among partners. A potential structure of a governing body or governing arrangement appears in **Figure 3**.

Figure 3. Governance Partners



State support can vary and depend on regional and local need for health and social care integration. States can support partnership development, identify the model (e.g. regional, multi-state, etc.) of integrated care that best meets state goals, align contracts with integrated health and social care in mind, and provide management and/or oversight of networks and resultant outcomes. Further, states can support CBO activities such as developing business operations and refining business acumen skills and capabilities, including expectations for integrated care, contractual and financial options, service menu determinations, and technology opportunities. States also have the chance to strategically align state Medicaid

policies (e.g., managed long-term services and supports) with CBO infrastructure. States can formulate guidance for CIHNs, focusing on how they can support credentialing. For example, Wisconsin included benefits and coverage for social services in their 1915(c) waiver.

It is important to determine the right balance of CBO representation within the network, participation or representation from health plans and systems, and the specific roles that state agencies can assume. This may look different in every state, or even between regions within one state, but involvement of the right partners at the leadership level can support successful CIHNs.

Scaling

Scaling CIHNs, growing the size and reach of these networks to allow for a greater geographical footprint within a region, state, or across multiple states, begins with understanding the importance of maintaining consistency of services, adhering to access standards, ensuring quality of care, and enabling data sharing across CBOs and health system platforms. Data governance, standards for health information exchange, billing, consent and privacy regulations, and closed-loop referrals must be established to achieve interoperability. One of the greatest barriers to interoperability is the ability to calculate the ROI to ensure sustainability and consistent standards. Networks in different communities, with varying architectures or available resources, can approach these goals differently.

CIHNs have moved forward based on what works best for the organizations that are coming together in partnership to form the network. For instance, some CBOs have joined existing networks, while others have formed CIHNs with other organizations in their own communities. One of the biggest considerations for these various approaches is the ability to finance start-up costs and manage service delivery at scale. Creating CIHNs or joining existing CIHNs allows CBOs to begin integrating social services with existing health care systems without having to assume all the risk of building a new system. CIHNs are beginning to look to potential collaborators to support other areas of scaling up. For instance, to further support their growth, CIHNs can turn to other experts to support the development of data or IT infrastructure. Adding some collaborators, such as IT vendors, will often come with costs (since CBOs will purchase the services of those vendors). However, if these partnerships enable CIHNS to form strong, holistic service delivery systems, these costs may yield a higher ROI.

As CIHNs scale and more and more partners come together, consistency will matter greatly. Services and processes must be consistent across settings – in the home, in the community, and in health systems. Building this consistency into contracts, quality certifications, and data sharing can lead to efficiency. For example, Bay Aging, a AAA in the state of Virginia, has successfully developed a CIHN that supports partnerships with health plans across the state. Their efforts focused on creating consistent services among partner CBOs and consistent

processes for coming into the network, subsequently expanding work with local health systems based on the established processes that Bay Aging put in place. With this focus on consistency, they successfully certified staff members and expanded contracts with MCOs, Veteran Directed Care (VDC) providers, and options counselors. All the CBOs that work together in the Bay Aging CIHN follow the same successful service guidelines.

To develop and scale CIHNs, stakeholders must coordinate their strategies for workforce development. Providing access to services is only beneficial if the network has the capacity and the staffing to deliver those services. CIHNs cannot scale up without a coordinated strategy to develop the size and skillset of the direct care workforce.

Identified Action Items

ACL's engagement with stakeholders over the last six months has produced several action items in the four key domains of integrating health and social care for payers at all levels. These action items appear in **Table 3**.

Table 3. Identified Action Items

Financing Social Care	Governance & State Leadership
▪ Develop provider-agnostic care delivery system of SDOH sustained through reimbursement from multiple payers ▪ Outline how to establish CIHNs as best-practice partnerships that supports the integration of funding and services ▪ Work with CBOs to market their value ▪ Position CBOs as collaborators, not competitors ▪ Share best practices with key partners	▪ Outline and clarify roles for funding, regulation, oversight, and policy development through collaborative efforts ▪ Seek clarification from federal partners to identify funding pathways and support in clarifying roles ▪ Determine how best to maximize revenue and funding at the state and local levels ▪ Ensure accountability with funds and adherence to regulations ▪ Support CIHN development and data integration efforts ▪ Share best practices with key partners
Technology	**Scaling**
▪ Continuously acquire data, aggregate data, analyze data, and act on the findings (4As) ▪ Build infrastructure to support data integration and interoperability by ensuring consent and sharing data ▪ Create a standardized means for referrals and ensure closed-loop referrals ▪ Catalog best practices and share with key partners, including state and federal partners	▪ Expand CIHN development, as well as data integration and interoperability at all levels ▪ Establish CBO-network credentialing process ▪ Establish a common process for developing partnerships ▪ Establish quality monitoring guidelines ▪ Lead or join together to form CIHNs ▪ Share best practices with key partners

Conclusion

ACL's engagement with stakeholders has proven fruitful. ACL gathered vital intelligence from key players, including those working on the front lines to help CIHNs mature and knit together regional networks into a network with nationwide coverage. Several pressing challenges remain, however, in the following domains:

1. Determining a network's value proposition and ROI for prospective partners
2. Shifting financing to value-based payments or similar risk- and outcomes-based models
3. Preparing to partner with health plans and health systems
4. Ensuring interoperability of data systems and databases
5. Clarifying the role of federal and state partners

It is important to note at the outset that valuable tools already exist to help NLEs and the CIHNs they head to meet some of these challenges – most notably, the tools available through the **Aging and Disability Business Institute** and the **HCBS Business Acumen Center**. It is unclear, however, how often networks use these resources. And there are some topics – such as health IT interoperability – that are not fully addressed by the tools these centers have made available.

Network Value Propositions and ROI

To market their services to prospective partners, especially payers, networks must determine their value proposition. How would an MCO benefit from purchasing SDOH from a CIHN? How would those services improve outcomes? What would the cost savings be?

While there are **tools** for **calculating ROI**, the tools alone are not enough. The inputs to those tools must be evidence-based. For example, how might nutrition assistance services help avert unplanned hospitalizations due to diabetes-related complications? There is a growing body of evidence that **SDOH services produce ROI**, but the evidence base remains incomplete. CIHNs will need to track this evidence base as it grows and incorporate it into their stated value proposition to be as concrete and persuasive as possible when negotiating with payers.

Preparedness to Partner

Networks must actively pursue engagement with state Medicaid agencies before those agencies contract with MCOs to help influence the terms and conditions of the contracts that Medicaid agencies eventually execute with these organizations, such that MCOs have a strong incentive – if not an outright requirement – to provide the kinds of social care services that networks can provide.

To partner with health systems and health plans, NLEs and their networks must be prepared to respond to Requests for Proposals for social services when they are released. To position themselves to enter such arrangements, NLEs must assess their preparedness internally beforehand – ideally, well before they contemplate responding. NLEs should conduct these self-assessments on a repeated basis that allows them to identify their strengths and weaknesses and incrementally improve in areas that require attention. Preparedness does not fall to the NLE alone. Indeed, NLEs must evaluate the stability of the CBOs in their network. Otherwise, as the entity that holds the contract with a health plan or health system, the NLE places itself at risk of failing to meet its contractual obligations.

Accountable Financing

Networks must shift their financing models from strict fee-for-service models to models that spread risk between networks and partners. One such risk-shifting model is value-based or performance-based purchasing, with networks being rewarded for creating positive outcomes among consumers and penalized for failing to prevent adverse outcomes.

Performance-based models are fundamentally rooted in accountability. To base their funding on performance, networks must have a realistic sense of whether their services can produce the outcomes against which their performance is measured. In other words, do their services meet the necessary quality standards? And if not, how might they improve the quality of those services?

Systems and Data Interoperability

CIHNs cannot function without health IT systems that track consumer needs, referrals, follow-ups, and outcomes, at minimum. Likewise, networks cannot expect to partner with payers without being able to share data, whether on a common platform or across platforms.

The sheer number of health IT platforms has grown dramatically in recent years, along with interoperability standards such as **HL7**. Networks must grapple with this rapidly changing landscape. Moreover, networks must remain alert to the pitfalls of adopting the purpose-built, proprietary systems that some health plans or systems may demand. Becoming locked into one platform or standard can impair a network's ability to contract with other payers in the future.

The fragmentation of standards can also impede efforts to scale networks from local contexts to regional or nationwide levels. Network A and Network B may be geographically adjacent, but if the two networks have adopted different platforms that cannot communicate, they will have a hard time knitting their networks together.

At a minimum, systems must be able to transmit data bi-directionally. In other words, they must be interoperable. In the absence of interoperability, individual networks may find themselves at a disadvantage, and plans to create networks of networks may be unachievable.

Federal and State Roles

CIHNs do not exist in a vacuum. They have relationships with the federal and state entities that fund and regulate them. Successful network development depends on NLEs and their partner CBOs having productive relationships with these entities, whether directly or (in the federal case) indirectly through state partners. To overcome all of the challenges listed above, state agencies will need to work closely with networks at different stages of development, from early/emerging to mature/high-functioning. For example, state agencies can work with networks to make full use of funding flexibilities. Medicaid agencies, for instance, can support networks by using HCBS waivers and Medicaid State Plan options to claim federal match for services and administrative activities that the state alone would otherwise be responsible for.

Federal agencies, for their part, will need to offer ongoing support, including funding opportunities, technical assistance, and guidance to networks directly, to state agencies, or to both. By helping to educate state agencies and local network partners and by creating or

encouraging standards, federal agencies can help promote the development of individual networks and facilitate the growth of networks over time into a nationwide network of networks that can offer social services to people wherever they live.

Shared Principles and Goals

As efforts to further establish and develop CIHNs continue, it is important to understand guiding principles for this work. These principles were developed, tested, and refined based on input from CBOs, health plan and health system leaders, and all attendees of the National Summit on Health Care and Social Service Integration. The overarching principle guiding all work is ensuring that stakeholders use a person-centered approach to the integration of health care and social services. Doing so help partners achieved the shared goals of trust, leadership, accountability, sustainability, and innovation.

Table 4 reflects the shared principles and goals emanating from the collective work of ACL, stakeholders, and Roundtable and Summit participants.

Table 4. Shared Principles and Goals

Overarching Principle: Use a person centered approach to integrate health care and social services.

Principle	Description
Trust	Uphold and preserve the confidence and respect of individuals.
Leadership	Co-lead and coordinate holistic services.
Accountability	Create a culture of performance and data driven quality improvement among all stakeholders.
Sustainability	Advance equitable shared financing of social care and shift to risk-based payment overtime.
Innovation	Evaluate and evolve interventions to improve service delivery, efficiency, and outcomes.

Moving forward, these principles, and everything learned from stakeholder engagement, will guide ACL's continued efforts to advance the integration of health care and social services. This work is ongoing in communities across the country, and ACL will support the work of all stakeholders and engage them in discussions to ensure that CIHNs are well positioned to effectively integrate services and improve the health of individuals in communities across all states and regions.

Appendix A: Stakeholder Engagement Activity Attendees

Enhancing Community-Based Networks for Nationwide Capacity Roundtable

Participant Name	Affiliation
Connie Benton-Wolfe	Aging & In-Home Services of NE Indiana
Jacob Reider	Alliance for Better Health
Brianna Brennan	Alliance for Better Health
Kathy Vesley-Massey	Bay Aging
Sharon Williams	Consultant
Abigail Morgan	Direction Home Akron Canton
Jennifer Raymond	Elder Services of the Merrimack Valley
Tim McNeill	Freedmen's Health
Paula Johnson	Houston Area Agency on Aging
Janice Sparks	Houston Area Agency on Aging
Jen Morgan	Center for Persons with Disabilities, Utah State University
Richard Petty	Independent Living Research Utilization
Brooke Curtis	Independent Living Research Utilization
Mary Kaschak	Long-Term Quality Alliance
Leigh Ann Eagle	MAC, Inc.
Sue Lachenmayr	MAC, Inc.
Lucy Theilheimer	Meals On Wheels America
Marisa Scala-Foley	National Association of Area Agencies on Aging
Karol Tapias	National Association of Area Agencies on Aging
Sandy Markwood	National Association of Area Agencies on Aging
Kathleen Cameron	National Council on Aging
June Simmons	Partners in Care
Bill Massey	Peninsula Agency on Aging
Dana Eidson	SARCOA (Alabama)
Rene Seidel	The SCAN Foundation

Roundtable Work Group

Participant Name	Affiliation
Connie Benton-Wolfe	Aging & In-Home Services of NE Indiana
Kathy Vesley	Bay Aging
Abigail Morgan	Direction Home Akron Canton
Jennifer Raymond	Elder Services of the Merrimack Valley
Marisa Scala-Foley	National Association of Area Agencies on Aging
Karol Tapias	National Association of Area Agencies on Aging
June Simmons	Partners in Care Foundation
Jim Vandagrifft	Preferred Population Health Management

Appendix B: Roundtable Work Group Paper

Community Integrated Health Networks: An Organizing Model Connecting Health Care & Social Services

March 1, 2020

Health care and community-based long-term services and supports have historically operated as separate delivery systems, with health care providers addressing individuals' medical needs and community-based organizations (CBOs) addressing functional needs and social determinants of health (SDOH). The lack of coordination between these equally important – but siloed – systems leaves the individuals who use them – older adults, individuals with disabilities, and caregivers – with the burden of navigating different service systems, leading to confusion, stress, and a higher probability of institutional care and related costs.

In this paper, we make the case that integrating these systems into *community integrated health networks* leads to better outcomes and lower costs. In addition, we describe a set of CBO network models, ranging from a local/regional level to a national level. These networks of CBOs operate at different levels and formalize contractual relationships with health care partners according to their size, capacity, population needs, and geographical reach.

Preamble: The Guiding Principles of the Organizing Model

The goal of the organizing model presented below is to promote a person-centered approach to integrating medical and social care in which the individual's preferences, goals, and interests are embedded across various services and touch points. It draws heavily from input provided by a work group of participants who attended the *Enhancing Community-Based Networks for Nationwide Capacity* Roundtable Meeting at the Washington, DC offices of the Administration for Community Living (ACL) on December 5, 2019. Following the Roundtable meeting, a subset of community leaders who have been developing networks over the last decade agreed to meet on a biweekly basis to further refine an organizing model for connecting health care and social services.

The Roundtable Work Group was guided by the following set of core principles on community integrated health networks:

1. **Trust**: Networks leverage established relationships in the community and in the home to ensure that individuals feel understood and supported.

2. **Leadership**: Social service and health care decision makers share leadership responsibilities in planning and managing social assessments, referrals, service delivery, and team-based, holistic care.

3. **Accountability**: Social service leaders implement a system of accountability and quality improvement at all levels using agreed-upon performance benchmarks, frameworks for data sharing and regular reporting, and data-driven strategies for improvement.

4. **Sustainability**: Networks finance services that address SDOH through multi-payer arrangements that build community capacity. Over time, they transition from a fee-for-service payment model to value-based/risk-based payment models for delivering social services in comprehensive, coordinated care environments.

5. **Innovation**: To maximize efficient delivery of services and health outcomes, networks implement, evaluate, and iterate evidence-based interventions and innovative care models.

Why Do We Need Community Integrated Health Networks?

A growing body of literature shows that CBOs are more likely to successfully expand their mission to support the diverse needs of individuals and families in the community if they belong to integrated networks with diverse partners. These studies offer crucial insight into why it is important to design and replicate effective approaches for network organization.

In a study of Accountable Care Organizations (ACOs), which have become early adopters of efforts to integrate medical care and SDOH, Murray, Rodriguez, and Lewis (2020) found that ACOs were often hampered by *not* being well-integrated into CBO networks that have already developed the capacity to address SDOH. They concluded that ACOs are more likely to succeed in integrating SDOH into their broader efforts if they implement local and regional networking initiatives that connect them to CBOs. They further concluded that such integration would also be improved by providing sustainable funding and developing standardized data on CBOs' services and their quality.

In one study, Brewster, Brault, Tan, Curry, and Bradley (2018) studied 16 Hospital Service Areas (HSAs) that performed either well or poorly across three key outcomes: ambulatory care-related hospitalizations; readmission rates; and average reimbursements per Medicare beneficiary. Using site visits and in-depth interviews with nearly 250 representatives of health care organizations, social service agencies, and local government bodies, they found that organizations in the high-performing HSAs collaborated more deeply and consistently with CBOs that provided social services than those in the low-performing HSAs.

In a separate study, Brewster, Kunkel, Straker, and Curry (2018) found that counties whose Areas Agencies on Aging (AAAs) maintained informal partnerships with a broad range of organizations in health care and other sectors had significantly lower hospital readmission rates, compared to counties whose AAAs had informal partnerships with fewer types of

organizations. Moreover, counties whose AAAs had programs to divert older adults away from nursing home placement had significantly lower avoidable nursing home use, compared to counties whose AAAs lacked such programs.

In a third study, Brewster, Yuan, Tan, Tangoren, and Curry (2019) explored the characteristics of effective collaborative networks. They collected survey data on collaborative ties among health care and social service organizations in 20 communities with high or low performance on avoidable health care use and spending by Medicare beneficiaries. They measured six types of ties: collaboration; referrals; information sharing; project cosponsoring; financial contracting; and joint needs assessments. Two features distinguished high-performing networks from low-performing ones: 1) health care organizations occupied more central positions (meaning they had the densest array of connections to other organizations); and 2) subnetworks of co-sponsorship ties were more cohesive (specifically, denser and more centralized around activities such as client referral and needs assessments). AAAs tended to be more central than any other type of organization because they are already positioned as network brokers and can thus serve as anchors for new networks of CBOs within HSAs.

The findings of these studies suggest that efforts to improve medical outcomes and lower costs by addressing SDOH will be more effective if CBOs, health plans, and health systems develop formalized partnerships within collaborative networks.

How Might Community Integrated Health Be Organized?

How should CBO-led networks be organized? To answer that question, we first define **community integrated health networks** as a coordinated group of visible and trusted CBOs led by a **NLE** that have entered a formal partnership with a health care organization. Headed by NLEs, community integrated health networks are scalable and can offer one-stop contracting for multiple proven interventions and services. These interventions can be conducted in an individual's home and in a person-centered fashion by a workforce trained in person-centered thinking, planning, and practice. These networks may benefit from using a centralized, coordinated model for service provision, administrative functions, and quality improvement. The NLE, which serves as the hub for coordinating the services of the wider network, provides a unified and consistent approach to program delivery across a geographic area. It can also provide administrative oversight and take the lead in governance responsibilities.

Establishing community integrated health networks led by NLEs gives these networks the capacity to:

- Deliver a broad scope of SDOH services
- Expand and evolve populations served by reaching more diverse consumers and traditionally hard-to-reach populations
- Build stronger administrative infrastructures
- Capitalize on economies of scale
- Provide expanded geographic coverage at various levels – community (within states), statewide, regional (across state lines), and national (multi-state)
- Offer one-stop contracting for multiple services with different payers
- Expand quality improvement initiatives and successes

A NLE allows private health care entities to efficiently contract with multiple community-based service organizations in a streamlined way. In response to health care payers across the country, NLEs can leverage existing national aging and disability networks. NLEs are rapidly forming new legal and organizational structures to help streamline and coordinate payments, implement a consistent referral and service delivery process, manage data flows, expand geographic coverage, and improve risk management. A significant advantage of NLE-led networks is their capacity to provide services at different geographic levels, such as 1) community-wide; 2) statewide; 3) regionally across state lines; and 4) national models across multiple states to meet the market demand of health plans' and systems' geographic footprint.

Because community integrated health networks can include public and private health systems and health plans, they have the power to serve individuals with complex medical, social, and functional needs, independent of the health plan in which they are enrolled or the health system through which they typically receive their medical services. In addition, as a majority of payers shift to value-based care, a NLE can contract with all willing and interested payers and providers in a given market that can share in the investment needed to evolve and sustain the community integrated health network. These networks can also evolve their approach to targeting populations in need based upon individual assessments and population level analytics and grow network capacity and service delivery to meet these needs accordingly.

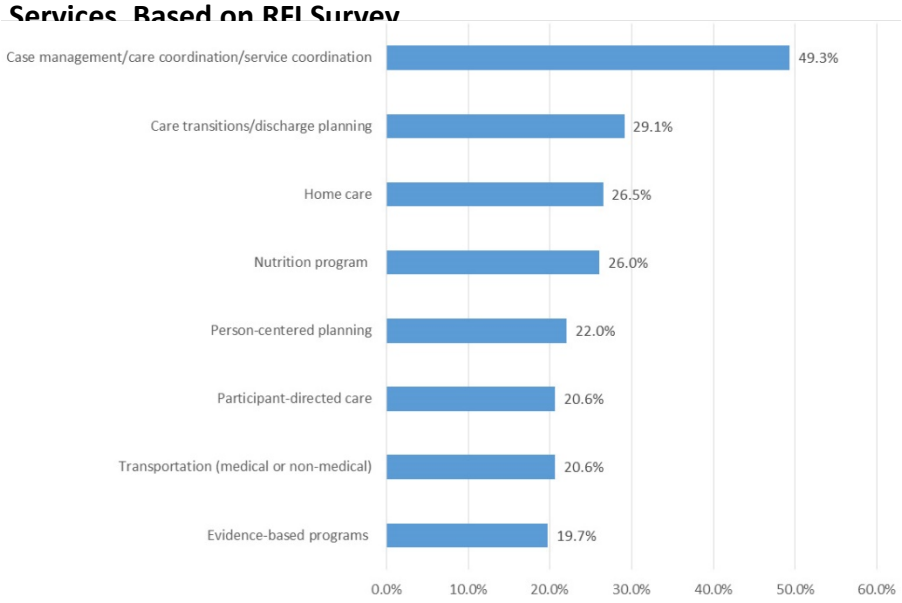
An example of an existing community integrated health network appears in Appendix A. It illustrates how one network, VAAACares, has used the NLE model to bring together CBOs and

health partners to improve outcomes for the individuals they serve while adhering to the key principles listed in the preamble of this paper.

Which Services Do Community Integrated Health Networks Offer?

According to a recent national request for information (RFI) survey by the Aging and Disability Business Institute (Kunkel, Wilson, Lackmeyer, and Straker, 2019), the most common health care contracting partners for CBOs (AAAs, CILs, and others) are Medicaid managed care organizations (MCOs), followed by state Medicaid plans and hospitals and hospital systems, respectively. Through a recent shift in the CHRONIC Care Act, CBOs are also beginning to partner with Medicare Advantage plans with such partnerships continuing to grow. The same survey revealed that nearly 250,000 individuals were served through contracts with health care partners, and 85 percent of respondents indicated that their contracts targeted high-risk or high-need groups. Finally, the RFI survey also found that the most common services provided under contracts were community home-based case management, care coordination, and service coordination.

Figure A. Percentage of CIHN Contracts Offering Various Services, Based on RFI Survey



Citation: Kunkel, Lackmeyer, Stracker, and Wilson (2019)

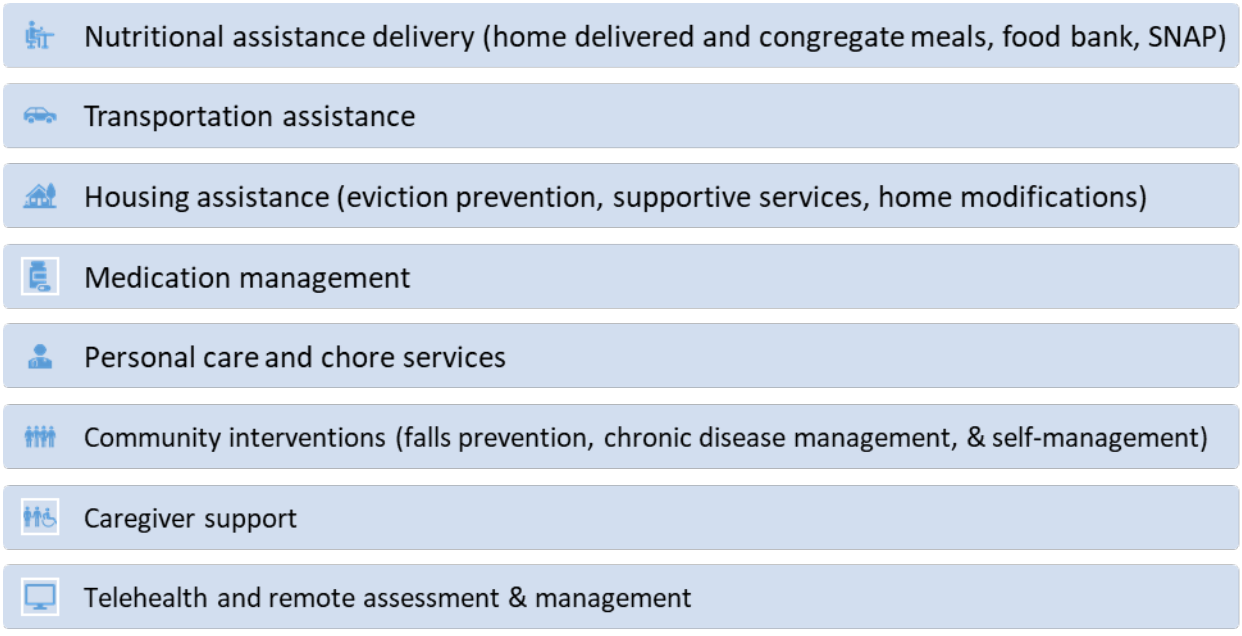
Community integrated health networks may offer a basic set of services. These commonly offered services could include those listed in the graphic below.

Figure B: Services That Community Integrated Health Networks Might Commonly Offer

Note that the services listed above do not represent an exhaustive list.

Community integrated health networks may also offer other types of services. The set of such services could depend on network capacity, the needs of the communities they serve, and demand from payers (including the willingness to pay a reasonable price). These other services could include those listed in Figure C.

Figure C: Services that Community Integrated Health Networks Might Offer Depending on Local Need and Demand

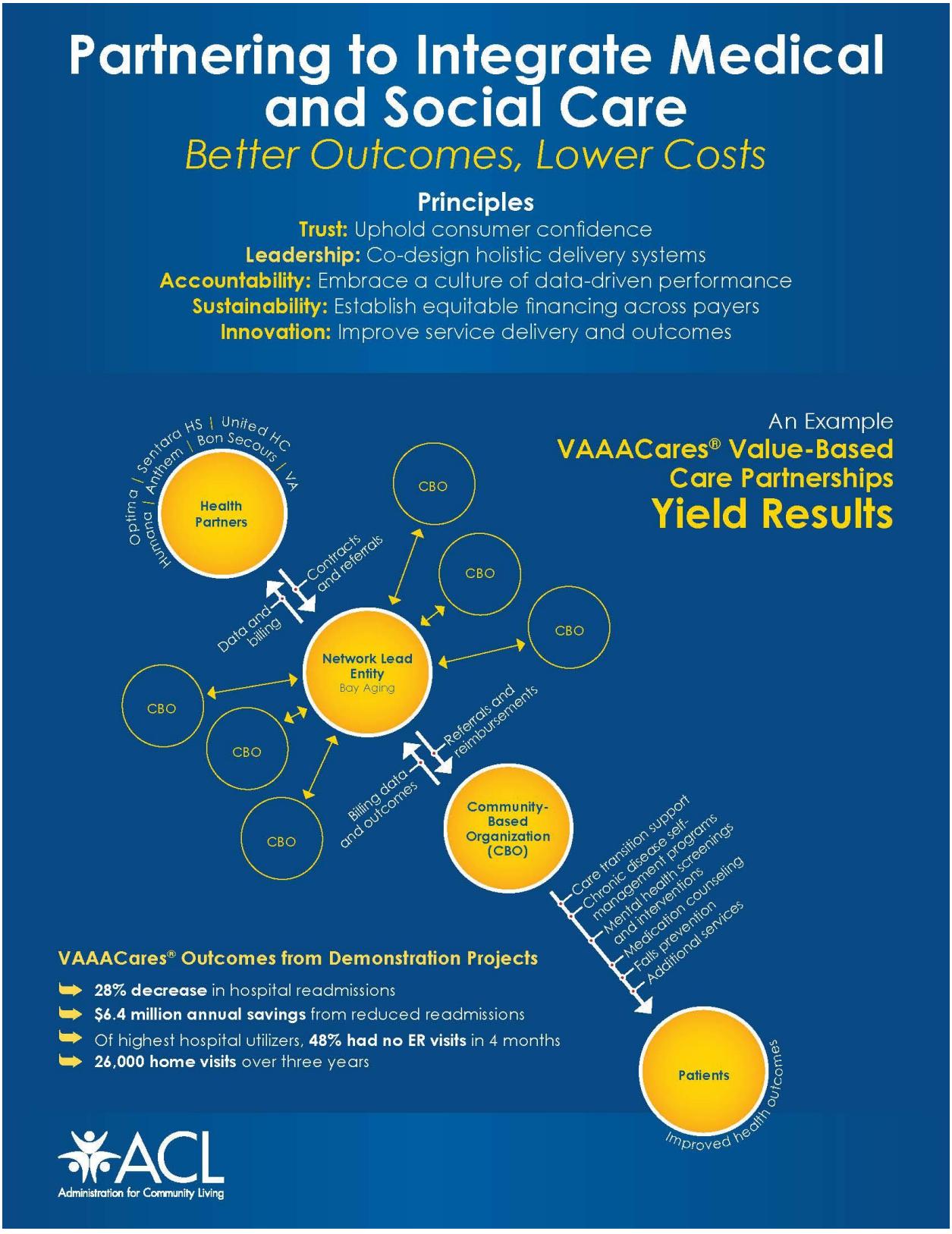


Again, the services listed above do not represent an exhaustive list.

Conclusion

We have presented a brief review of the benefits of network integration and suggested ways that community integrated health networks led by NLEs might be organized at different geographic scales. We have also enumerated services that we believe community integrated health networks may commonly offer, along with services that such networks may offer less commonly, depending on capacity, the needs of the community, and demand from payers.

Appendix A: Example of Community Integrated Health Network, VAAACares



Appendix B: Glossary of Abbreviations

Acronym	Meaning
AAA	*Area Agency on Aging*
ACL	*Administration for Community Living*
ACO	*Accountable Care Organization*
CBO	*Community-Based Organization*
CIL	*Center for Independent Living*
HSA	*Hospital Service Areas*
MA	*Medicare Advantage*
MCO	*Managed Care Organizations*
NLE	*Network Lead Entity*
RFI	*Request for Information*
SDOH	*Social Determinants of Health*

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Appendix C: National Summit on Health Care and Social Service Integration Sessions

Table C-1. Vision for the Future

Main Theme	The main theme of this session was that function drives Medicare and Medicaid spending, and stakeholders need models that address this fact. Moreover, stakeholders need alignment across payers, sustainable investment, and a nationwide CBO network to create a better model for screening, risk, and accountability sharing. One way to build out infrastructure and increase cross-payer alignment is to have social service professionals act in new "triage" roles that would help address barriers without putting undue burdens on clinicians.
Opportunities	• The need to invest sustainably. • The need to align payers across incentives and regulations. • The need for CBOs to look at the overall cost at the individual level and use that to make the business case as to why care delivery is important. • At the local level, referrals, quality monitoring, and reporting require standardization. • A shift in thinking in terms of competition to thinking in terms of cooperation in needed. • For their part, CBOs must ensure they are educating their state partners.
Actions	• Create a better model to address functional limitations. • Develop standardized data systems and interoperability protocols so that moving to a network of CBOs is more feasible. • Create a systematic screening process. • Create "social work triage" as a specific role to help address barriers to care without putting undue burdens on clinicians. • Craft a plan for providing services to individuals with are dually eligible for Medicare and Medicaid, including how to manage the associated payment complexities. • CBOs must find a way to communicate regularly and clearly with health plans and health systems.

Table C-2. Current State of Health care and Social Service Integration

Main Theme	This session reviewed the current state of partnerships between health care and CBOs, and what assets/resources are collectively needed to reach the desired future. One way to move forward is by leveraging emerging payment and technology opportunities, including the need for collaboration across payers and providers for sustainable, community-wide integration of services.
Opportunities	• In 2018, there were 10 states that showed no evidence of network development. It is important to work with those 10 states to build networks and the capacity to provide the most commonly provided services. • Without policy opportunities or policy guidance, health markets may not interoperate.
Actions	• Continue to use business intelligence to build and strengthen partnerships between CBOs and health plans and systems so that everyone has access. • Look at consolidating the 20,000 aging and disability service providers, AAAs and CILs, to have an organized network with optimal service delivery. • Health plans and health systems should work with CBOs in to learn from them and teach them more about value-based payment models.

Table C-3. Shared Goals and Principles

Main Theme	In this session, ACL conducted live polls of the five key attributes of a successful CIHN: trust, leadership, accountability, sustainability, and innovation. Summit participants expressed overall agreement on the importance of individual principles, all of which scored above a 4.1 on a Likert scale (where 1 was “strongly disagree” and 5 was “strongly agree”). However, strong opinions were raised about the narrow framing of accountability; the narrow view of which parties are involved in financing; and the negative connotations of the word “leverage.”
Opportunities	Review the audience feedback captured electronically during this session to see what changes might be made to improve these principles.

Actions	• Revise the definition of Accountability to incorporate a focus on the community. • Broaden the scope of financing opportunities to incorporate all stakeholders and partners. • Incorporate both private and public sector investments in the social system. • Revise the language to avoid the use of the word "leverage." • Develop a set of concrete next actions steps.

Table C-4. Lunch and Fireside Chat Plenary

Main Theme	The Centers for Medicare and Medicaid Services, Center for Medicare and Medicaid Innovation (CMMI) would like to see more partnerships between community-based organizations (CBOs) and payers. CMMI needs more data about decision-making for accountable care providers, community resources, and connecting individuals with services and outcomes to determine where to invest and who to partner with to maximize return on investment (ROI).
Opportunities	• There is an urgent need to determine how to leverage data to target populations with the right services in the right place at the right time – and thereby maximize ROI. • A promising course of action is to engage Medicare Advantage plans to partner with CBOs to target individuals based on socioeconomic status, specific health conditions, or other SDOH. • CMMI can directly or indirectly engage, but the bar for making new investments is high. A crucial first step is to accumulate an evidence base that enables stakeholders to know *which* populations to target and *how* to target them.
Actions	CMMI and its partners should consider taking steps to: • Better understand the gaps and opportunities across siloed systems. • Describe the kinds of data they wish to collect. • Develop a set of standardized patient assessment data elements.

Table C-5. Key Opportunities for States to Advance Social Determinants of Health

Main Theme	State Aging, Disability, and Medicaid leaders can leverage existing policies and authorities to advance the integration of medical and social care through CIHNs.
Opportunities	• State Medicaid directors are currently looking for more clarity around what they can do with 1915(c) waivers. • State Medicaid directors should think about ways to collect high-quality data on service utilization and costs so they can lower costs and improve outcomes. • Turnover rates among state staff can be high. To reduce turnover, state agencies can cultivate relationships that allow them to work together on a common problem. • Continue dialog around who would pay first in a multi-payer system, learning from what Medicaid agencies have done in the past.
Actions	• Develop an overall state framework as well as state-specific frameworks to help state leaders understand the local service delivery system, resources, policies, and services. • Develop or improve data sharing and data exchange. At the same time, develop a deeper understanding of laws, rules, and protocols regarding data privacy and security. • Given the high numbers of people usually on waitlists to receive community LTSS, states should think creatively about ways to generate new revenue sources to serve more people.

Table C-6. Breakout Session: Scaling Networks of CBOs

Main Theme	Significant resources are needed to evolve and expand CIHNs. Shifting towards a value-based environment is important, although fee-for-service models should also be given careful consideration. This shift could help networks move quickly on several fronts: • Develop networks at all levels • Align data at all levels • Use advocacy efforts to maintain momentum • Determine common processes that can be applied across different types of partnerships • Promote needed investment from the Department of Health and Human Services (HHS), especially ACL and CMS, as well as state agencies

Opportunities	• Network development all levels • Network data alignment at all levels • Joint efforts with advocacy groups • Necessary investment from HHS, including ACL and CMS
Actions	• Develop processes and systems for credentialing and quality monitoring • Develop readiness assessments across network partners • Lead or join a network • Share best practices to identify solutions for new populations • Tie Health care Effectiveness Data Information (HEDIS) scores to aspects of network development and maturity

Table C-7. Breakout Session: Technology Enablers and Barriers

Main Theme	The path toward action in the domain of IT has four steps in a continuous process (the "Four A's"): 1. *Acquire* data 2. *Aggregate* data 3. *Analyze* data 4. *Act* on the findings Technology – including health information exchanges (HIEs) – enables organizations to take patient records and follow their status and understand their clinical needs. There are five major barriers to adopting technology that would facilitate interoperability: 1. Limited interoperability 2. Data complexity 3. Translating use of health data into ROI 4. Sustainability 5. Lack of consistent standards

Opportunities	• Promote interoperability • Capture and maintain patient consent • Develop infrastructure throughout the network • Promote closed-loop referrals • Incorporate HIE into a more general view of infrastructure needs • Resolve the confusion that arises from competing application-program interfaces (APIs) for different systems • Focus on interoperability from hub to hub (NLE to NLE) • Collect data not only from medical sources, but also from behavioral and social networks, with data traveling bi-directionally • Tie data to payment • Explore standards such as HL7 referral standards • Favor standards that are technology agnostic • Catalog current best practices, as the Office of the National Coordinator (ONC) did in 2015
Actions	• Identify and promote best practices • Create easy integration • Promote discussion among providers, payers, technology vendors, and organizations that set technology standards

Table C-8. Breakout Session: Federal and State Roles

Main Theme	State Units on Aging (SUAs) should engage more fully in developing policy and designing conversations to support the development of these networks. As states expand their work in this area, SUAs should collaborate actively with all agencies and stakeholders.
Opportunities	• SUAs should get AAAs more involved in Business Acumen training, recognizing that there are internal changes that may need to happen to stay involved in the development of these networks. This training may help AAAs improve their capacity to negotiate on their own behalf. • Across the suite of programs it funds, states can require that recipients of those funds work with CBOs, thus giving CBOs an opportunity to demonstrate they could do the work. • SUAs should be involved in developing policy – aligning the work across agencies so that they avoid confusing, misaligned guidance going out to the CBOs. • States should support the necessary IT and data analytics. • SUAs should work with state Medicaid agencies to develop strategies for providing joint support to CBOs.

Actions	• Clarify roles (funding, regulations, oversight, policy, etc.) by bringing together entities to determine who is responsible for what and how every organization can maximize funding and revenue. • Seek clarification from federal partners that fund states, especially ACL and CMS, and request additional guidance when needed. • SUAs should ensure that they are fully accountable for the funding they receive and are compliant with relevant laws and regulations.

Table C-9. Breakout Session: Financing Social Care

Main Theme	Specific, replicable best practices and opportunities exist to promote the integration of medical and social care. These integration practices should be promoted by data analytics teams, contractors, health care economists, ACL, CMS, and state Medicaid agencies.
Opportunities	• With guidance from CMS on how these practices could be implemented under the current regulatory framework, providers would be more likely to replicate these practices. • CBOs continue to encounter difficulties demonstrating the ROI of their services; to contract with payers such as MCOs, they will need help overcoming this barrier. • One step toward demonstrating ROI is for CBOs to differentiate their products.
Actions	• Develop a care delivery system to address SDOH that will be sustained through the capture of reimbursement from multiple payers. • One best practice might be a system that triggers reimbursement from heath systems and health plans for care management services. • Work with CBOs to calculate the ROI of their services and sell their market value to prospective purchasers (Medicaid and Medicare claims data may be a useful source of data). • Use Medicaid and Medicare dollars to finance infrastructure and/or social services. • MCOs and CBOs need to communicate clearly so that each understands that the other is a partner, not a competitor.

Table C-10. Bringing It All Together

Main Theme	This session concluded the Summit, highlighting the main themes of the day and outlining potential next steps. Key themes included state policy frameworks, working across payers, and the sustainability of network efforts.
Opportunities	• Use existing assessment tools, the social service workforce, and evidence-based practices to build out a curriculum for CBOs. • Outline the subset of social interventions that will generate the highest ROI. • Develop frameworks for states to share resources with each other. • Identify which one-time investments need to be made up front and which can be deferred.

Actions	• Advocate for state policy frameworks that incorporate the Aging Network's mission. • Develop frameworks for sharing resources. • Clarify the pathway to addressing SDOH through CBOs. • Provide guidance on how all stakeholders can work together to achieve the best outcomes.