



The Role of Community-Based Organization Networks in CalAIM: Seven Key Considerations

The California Department of Health Care Services (DHCS), counties, and Medi-Cal managed care plans (MCPs) are ramping up to meet the ambitious objectives of CalAIM (California Advancing and Innovating Medi-Cal), a five-year statewide health care reform plan that centers on a population-based approach, prevention, and whole-person care.¹ Successful collaboration between MCPs and community-based organizations (CBOs) of all sizes will be important to CalAIM's success, yet barriers exist for both MCPs and CBOs to create these collaborations.

CBO networks — a group of CBOs led by a network lead entity (NLE), or neutral convener, for the purpose of contracting with a health care organization — may help. This brief focuses on explaining the roles, opportunities, and challenges that CBO networks present in the context of CalAIM. Based on a series of key informant interviews (see appendix on page 14), it outlines considerations for the potential use of CBO networks, including the potential benefits and hurdles from the perspective of CBOs and MCPs. It also identifies the resources and supports needed to foster the development of effective CBO networks.

Introduction

In January 2022, DHCS began implementing CalAIM with a vision to extend supports and services beyond health care settings and to meet Medi-Cal members where they are by addressing their full range of clinical and nonclinical needs.

Enhanced Care Management (ECM) and Community Supports (CS) are foundational components of CalAIM

(see box on page 2). ECM is a new statewide Medi-Cal benefit available to select “populations of focus” that will address clinical and nonclinical needs of the highest-need enrollees through intensive coordination of health and health-related services.² Enrollees will have a single lead care manager who will coordinate care and services across the physical, behavioral, dental, developmental, and social services delivery systems, meeting enrollees wherever they are — on the street, in a shelter, in their doctor's office, or at home — to make it easier for them to get the right care at the right time.

Community Supports, also known as *In Lieu of Services*, are new statewide services offered by MCPs as cost-effective alternatives to traditional services or settings designed to address the health-related social needs of Medi-Cal members. DHCS has approved 14 Community Support services, and MCPs are encouraged to offer as many as possible (see box on page 2).

As part of ECM and the delivery of CS, MCPs will be required to partner with community-based organizations to provide the array of nonclinical social services. CBOs interested in participating in CalAIM will need to negotiate contracts with MCPs, adhere to new privacy and reporting requirements, and adapt to new workflows, which for many will be a departure from their traditional operations.

While large and well-resourced CBOs may have an infrastructure in place to partner with MCPs, small to midsize CBOs are less likely to have the capacity and experience to enter into contractual relationships, be able to take on financial risk, or have the capability to build staff skill sets and bandwidth.³ According to

the National Council of Nonprofits, 88% of nonprofits have an operating budget of less than \$500,000, employ 10 or fewer, and often rely on volunteers to support programming and operations, which may limit smaller California CBOs in their ability to engage in CalAIM.⁴

Despite their small size, however, these CBOs play a vital role in addressing the nonclinical needs of

community members, including providing job training, housing and tenancy support, behavioral health services, violence prevention, and food and nutrition services. Additionally, as trusted community providers, CBOs are critical partners in achieving health equity by elevating the voices of marginalized communities and vulnerable community members, and providing culturally relevant, equitable, and strategic solutions to community challenges.⁵

Foundational Components of CalAIM

Populations of Focus for Enhanced Care Management

- ▶ Individuals and families experiencing homelessness
- ▶ People who receive a lot of acute services
- ▶ Adults with serious mental illness / substance use disorder and children/youth with serious emotional disturbance or identified to be at clinical high risk for psychosis or experiencing a first episode of psychosis
- ▶ People transitioning from incarceration
- ▶ People at risk for institutionalization and eligible for long-term care services
- ▶ Nursing facility residents who want to transition to the community
- ▶ People enrolled in California Children's Services with additional needs beyond the qualifying condition
- ▶ People involved in, or with a history of involvement in, child welfare (including foster care up to age 26)

Community Supports Services*

- ▶ Housing transition navigation
- ▶ Housing deposits
- ▶ Housing tenancy and sustaining
- ▶ Short-term and posthospitalization housing
- ▶ Recuperative care / medical respite
- ▶ Respite services
- ▶ Day habilitation programs
- ▶ Nursing facility transition / diversion to assisted living facilities
- ▶ Personal care / homemaker services
- ▶ Environmental accessibility adaptations / home modifications
- ▶ Medically tailored meals
- ▶ Sobering centers
- ▶ Asthma remediation

*Source: *Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide* (PDF), DHCS, June 2022.

As DHCS, counties, and MCPs ramp up to deliver ECM and CS, CBOs of all sizes will be important players in meeting the ambitious objectives of CalAIM of delivering person-centered, whole-person care, addressing the social drivers of health, reducing disparities, and improving quality outcomes.⁶ Yet barriers exist for both MCPs and CBOs to collaborate in this new environment. Contracting with several CBOs to deliver ECM and CS may create challenges for MCPs, such as the time and expense to execute contracts with multiple providers, providing oversight, ensuring fidelity to programs and services, and ensuring data and security compliance.⁷ Conversely, while CBOs may be well-positioned to deliver ECM and CS, many may lack the experience and ability to enter into relationships with MCPs. CBO networks (see sidebar) are a potential model that may help to overcome challenges for MCPs and CBOs by streamlining contracts, helping CBOs engage with MCPs collaboratively, scale the delivery of nonclinical services, and help to balance negotiation and collaboration power between the entities.

A CBO network is a group of CBOs led by a network lead entity (NLE), or neutral convener, for the purpose of contracting with a health care organization. These networks are scalable and can provide streamlined contracting for multiple services or interventions. An NLE serves as the hub for coordinating services of the wider network, provides a unified and consistent approach to delivery across a geographic area, provides administrative oversight, and leads governance responsibilities.

Source: Martie Ross and Paul Cantrell, *Resource Guide — Building a CBO Network for Health Care Contracting: Choosing the Right Model* (PDF), Aging and Disability Business Institute, January 2022.

To inform a better understanding of the roles, opportunities, and challenges that CBO networks might present in this new policy landscape, the Center for Health Care Strategies (CHCS), through support from the California Health Care Foundation, conducted key

informant interviews with subject matter experts, representatives from California-based and national CBO networks, as well as MCPs (see appendix for a list of interviewees). This brief outlines considerations for the potential use of CBO networks in CalAIM based on the interviews, including detailing potential benefits and hurdles associated with the formation of these networks from the perspective of CBOs and MCPs, and identifying the resources and supports needed to foster the development of effective CBO networks.

CBO Networks: Definition, Financing, Results

CBO networks come in various shapes and sizes. Nonprofit Finance Fund recently released a report that captures the wide range of CBO network types throughout the country.⁸ While some networks are place-based and coordinate on an array of services, others serve a specific population (e.g., older adults or families with children) or a specific issue (e.g., housing instability or food insecurity). In practice, some networks operate with a backbone entity that provides administrative or contracting support, or both, on behalf of CBOs within the network. These backbone organizations, also known as network lead entities (NLEs), are often nonprofit organizations that serve as a hub for coordinating services of a wider network of CBOs. An NLE can provide administrative oversight, assume governance responsibilities, and serve as a fiscal and contracting agent acting on behalf of CBOs within the network structure. This brief explores a range of network models, including those that perform administrative functions on behalf of member CBOs (see sidebar on the United Way of San Joaquin County, page 5), as well as contracting and program coordination functions (see sidebar on C3 Community Assistance Program, page 6, and the San Diego Wellness Collaborative, page 9).

According to Nonprofit Finance Fund, network functions are financed in a number of ways, including through grants and contributions from local

philanthropy and governments and from contracts with state, county, and local agencies, as well as health care organizations, membership dues from participating CBOs and health care partners, other earned incomes (e.g., from services provided), and in-kind contributions.⁹

Existing evidence supports the idea that CBO networks can improve efficiencies for network members, have a positive impact on health outcomes, and offer significant return on investment.

Pathways Community HUB

The Pathways Community HUB, for example, is a well-established model that leverages community health workers to identify and connect those at the greatest risk for poor health outcomes to necessary medical, social, and behavioral health services.¹⁰ The HUB, or neutral convener at the center of the model, provides administrative functions for participating clinical and community-based providers and is a centralized point of access for health care partners to refer people to services.¹¹ A recent evaluation demonstrated that high-risk pregnant women who participated in the Pathways Community HUB model were significantly less likely to deliver a baby that required neonatal care, compared to women who did not participate in the model, and their participation resulted in significant cost savings.¹² A Pathways Community HUB is currently emerging in the San Joaquin region, with the San Joaquin Community Foundation acting as the local HUB.

Seven Considerations for Using CBO Networks in CalAIM

The following section captures themes heard throughout the key informant interviews. While contracting relationships between MCPs and CBOs to deliver ECM and CS are nascent, and the development of CBO networks providing these services are relatively uncommon, informants shared lessons on CBO collaboration and insights on the benefits of CBO network formation from CBO and MCP perspectives, the required elements to support successful CBO network formation, and perceived challenges.

1. CBO Networks Can Increase Efficiency for CBOs and MCPs

CBO networks can offer efficiencies for both CBOs and MCPs. CBOs have long been in the business of addressing clients' nonclinical needs and have a deep understanding of diverse characteristics of their communities. A CBO network could support an MCP's understanding of the communities they are serving, a critical component of addressing health equity, by being a collective voice for the range of needs and priorities within a given MCP service area. An effective network could address MCPs' desire to streamline contracting for ECM and CS with one lead entity, rather than pursuing multiple contracts, and could also provide MCPs with a reliable infrastructure that could support reporting requirements and consistency across programs and services. MCP representatives interviewed noted that partnering with an NLE, rather than one-on-one with CBOs, offers a single contracting relationship with a wide range of CBOs and also potentially provides MCPs with a diverse and expert workforce to deliver ECM and CS at a larger scale. MCP interviewees noted that the administrative simplicity of contracting with an NLE, particularly within a specific region, could potentially reduce the fragmentation of care delivery, and improve access and health outcomes for members.

From the perspectives of CBOs and others interviewed, many do not have the capacity or financial resources to build required data infrastructure and privacy systems or have the in-house expertise to negotiate contracts with MCPs. CBO respondents noted that an experienced NLE could help CBOs navigate the complex landscape of contract negotiations with MCPs, manage reporting requirements, assist with business operations, and assume responsibility for provider credentialing and certification (see sidebar on United Way of San Joaquin County).

Per guidelines from the Centers for Medicare & Medicaid Services (CMS) and DHCS, providers are required to procure a National Provider Identifier (NPI) to deliver services, including ECM and CS.¹³ CBO informants noted that this was a time-consuming, intensive process and something many smaller CBOs may have difficulty completing. Additionally, MCPs have their own independent CBO vetting processes, which adds additional administrative burden and expense for CBOs. Interviewees noted that an NLE could support CBOs in these certification and credentialing processes, which would decrease CBO burden and increase their ability and willingness to participate in CalAIM. Interviewees also noted that a CBO network could free up CBOs to deliver services, rather than “getting bogged down” with the administrative components associated with partnering with health care entities, including MCPs. A few respondents shared that in addition to an effective NLE, CBO network partners are also a critical source of support and information for each other, and that establishing cross-CBO learning opportunities can support effective networks and their operations.

United Way of San Joaquin County: Supporting Community Collaboration

Nearly 70% of CBOs in San Joaquin County have operating budgets of less than \$55,000, making the administration of business processes challenging. Recognizing the limited capacity of many CBOs, the United Way of San Joaquin County serves as a fiscal sponsor, providing back-office operations like human resources, payroll, benefits administration, claims processing, and invoicing. CBOs pay a modest annual fee to the United Way to provide these services, freeing up staff to deliver on their core missions. In addition, the United Way of San Joaquin County serves as a neutral convener of the Connected Community Network (CCN),* a multistakeholder collaboration designed to address the health-related social needs of San Joaquin Valley community members. In partnership with San Joaquin County, 2-1-1, and Dignity Health, the United Way provides CBOs access to the community resource and referral platform Unite US. The CCN vision is to create a network of clinical and community partners all working together to provide appropriate medical and social need referrals to county residents, with a special focus on vulnerable, at-need populations. Unite US streamlines coordination by linking organizations that provide direct services to their communities, and allows community service providers to send, receive, and track referrals to resources, as well as provide the tools to collect data on needs, resolutions, and outcomes.

Funding for the CCN comes from an innovative model called the “community bank” concept. Funding partners, including health systems, payers, state and city governments, and local businesses, sign three-year contracts to commit funding to the community bank. Stakeholders also pay annually to support community infrastructure costs, including the 2-1-1 call center, and an administrative fee for the United Way, which serves as the fiscal agent, establishes funder relationships, identifies opportunities for growth, maintains contracts, and ensures community and CBO capacity to deliver services.

* “Connected Community Network (CCN),” United Way of San Joaquin.

Project Access Now: C3 Community Assistance Program

Project Access Now (PANOW), a Portland-based CBO, operates a network of CBOs to connect patients discharging from the hospital, as well as qualified Medicaid members, with needed health care, nonmedical services, and other community resources. The C3 Community Assistance Program (C3CAP) is supported by local hospital systems and the state's Medicaid managed care organizations — coordinated care organizations — and is designed to help those people successfully transition from the emergency department and inpatient hospital settings back to their homes by addressing health-related social needs that impact health and recovery. Support staff at hospitals and health plans collaborate with C3CAP specialists to identify at-risk patients through a screening process and connect those eligible to needed services, such as transportation, respite care, medication assistance, and temporary housing.

Participating health care entities pay PANOW directly for the goods and services required, as well as a tiered administrative fee based on the referral volume. PANOW acts as a “utility” for health care entities by managing referrals, coordinating payments, overseeing procurement of services, and maintaining the network of participating CBOs. PANOW facilitates contracts with CBOs, which allows them “to do what they do best” by delivering care and nonclinical services. The network also relieves significant administrative burden for health care partners, as PANOW coordinates and contracts with over 200 CBOs in the Portland region. Each year, C3CAP provides over \$3 million in goods and services, serves 10,000 community members, and fills more than 20,000 service requests.

Source: *C3 Community Assistance Program: Here for Community, Here for Providers* (PDF), Project Access Now, accessed July 26, 2022.

2. Opportunity Costs Are High for CBOs

The CBO representatives who were interviewed reflected that establishing a network requires significant time and trust between partners. Network interviewees reported that CBOs had a long history of collaboration, as well as experience working with the health care sector, which primed discussions around network development. In addition to trust and long-standing relationships, CBO network respondents noted that significant time was required to align on a vision and mission for the network, agree on a governance structure and internal management processes, establish technology systems across the network, as well as agree upon service and program delivery standards and reporting requirements. Some informants noted that without up-front capital, it will be very difficult for CBOs to come together to create a network. Citing “few reserves” and a “stretched workforce,” interviewees noted that there is simply not the staff capacity or resources necessary to explore network formation, let alone create a networked structure.

Several interviewees suggested that a lot of education is required to persuade CBOs to come together to form a network entity. Historically, because of very limited revenue sources, compared to health services entities, CBOs often operate with a “scarce resources” mentality and on business models centered on grant-funding sources. CBO leaders are “very protective” of their clientele, and relinquishing some control to a larger network structure, or lead organization, and moving from competitors to collaborators, is a potential barrier. Some interviewees noted that profit advantages need to be clearer to CBO CEOs for them to be willing to share power with a third party. That said, some CBO respondents noted that shared learning opportunities and dissemination of best practices among CBOs has been an effective strategy for encouraging partnership activities and network development. In addition, when MCPs have provided training and capacity building support to CBOs, this process has helped to address the significant opportunity costs

associated with developing partnerships to address social needs, as well as initiating conversations about network development.

“You’d need a very savvy and well-resourced organization to serve as a backbone entity. They would need a lot of flexibility, capital on hand, and back-end support to coordinate across CBOs. And then this organization would have to act in the best interest of all the CBOs in the network, which seems like a hard thing to achieve.”

— CBO representative

In the California context, interviewees noted that many CBOs are negotiating contracts directly with MCPs rather than working through an NLE. These CBOs have long-standing relationships with MCPs, as well as the counties in which they operate, and the amount of legwork to develop a network was deemed not in the best interest of the CBO. Several CBO respondents noted that the administrative rate available through ECM and CS contracts is relatively low, making hiring additional staff to oversee the coordination of services across organizations difficult to cover. There is also a tension for CBOs to independently contract with MCPs, especially during the rollout of CalAIM, to avoid missing out on a partnership opportunity. This desire by individual CBOs to establish contracts with MCPs, which in many instances has been successful, makes the need to establish a network less imperative.

Respondents repeatedly cited technology requirements as a barrier to CBO network formation. CBOs may use different technology platforms — sometimes to meet MCP requirements — and investments in additional technology systems is prohibitively expensive. While technology will play a substantial role in streamlining billing, referrals, communication, and data collection and reporting, high-functioning

networks will be “built on relationships, not technology.” Making the case to MCPs on the value of services or programs provided requires data, but the burden to collect data in a way that resonates with the health plans falls to CBOs. While a network structure could support data collection and analysis, there are significant associated up-front costs.

3. Leadership, Vision, and Resources Are Required

While many CBOs understand the value of forming a network to deliver ECM and CS, gaps in understanding effective models persist. Leadership, vision, and resources are key ingredients to establishing effective networks. An effective leader, including an NLE, could broker relationships and contracts among both CBOs and MCPs, and could spearhead discussions around identifying the specific functions and roles within CBO networks, help to operationalize the key functions of a network structure, and advocate on behalf of the network in the health care system more broadly.

Findings from a Nonprofit Finance Fund report,⁸ developed through its Advancing Resiliency and Community Health (ARCH) initiative, shed light on the experiences CBO networks face when contracting with health care entities and plans. These include the significant opportunity cost required to explore partnership relationships, lack of clear payment mechanisms and rates, misaligned missions and business models, and an expectation that CBO networks will make significant investments to participate in pilot projects to demonstrate a return on investment without the guarantee of a long-term contract or sustainable revenue. CBO networks in the ARCH initiative (see sidebar, page 8) sought to transform the health care system by coordinating care with health care organizations, but divergent missions and care delivery approaches made contract negotiations unworkable for the most part.¹⁴ To encourage equitable and accessible partnerships between CBO networks and MCPs, learning opportunities for MCPs that promote the understanding of CBO strengths and core functions could enable

MCPs to be more responsive and adaptive to the needs and capabilities of CBOs and their networks to deliver ECM and CS, as well as other programs and services.

In the CalAIM context, informants perceived little flexibility for CBOs to negotiate ECM and CS contracts, and that CBOs are in a “take-it-or-leave-it situation,” which would be true regardless of whether CBOs were part of a network. Some suggested that without a significant caseload of ECM-eligible Medi-Cal members, negotiating contracts with MCPs will be challenging, as will hiring full-time case managers to deliver ECM because of insufficient revenue. Interviewees reflected that, while some have successfully negotiated contracts with MCPs in the past, for other CBOs this uncertainty makes it challenging to take on ECM and CS contracts, and networking to do so is less appealing.

Advancing Resiliency and Community Health Initiative

The Advancing Resiliency and Community Health initiative was launched by Nonprofit Finance Fund in response to the growing momentum around the idea that partnership and contracts between CBOs and health care organizations could provide new funding streams for services addressing social determinants of health. Nonprofit Finance Fund partnered with three CBO networks — EngageWell IPA of New York, Thomas Jefferson Area Coalition, and Metropolitan Alliance of Connected Community of Minnesota — to explore what it takes for CBO networks to partner with health care. A series of resources was produced on lessons for building partnerships and pursuing contracts with health care organizations.

For more information, see *Lessons Learned from Partnerships Between Networks of Community-Based Organizations and Healthcare Organizations*, Nonprofit Finance Fund, 2021.

4. A Neutral and Trusted Convener Is Required

Many networks have formed organically and have developed over decades of collaboration. The partners in established networks have a long history of working together, including through pilot programs and initiatives, and have developed trust and understanding of each other’s missions, staff capabilities, and service delivery approaches. Many networks form over a shared mission or goal, and in California, many clinical and community partners have established connections through the Medicaid Health Homes and Whole Person Care pilots.

For any network to flourish, interviewees reflected that significant amounts of time and space are needed to pull stakeholders together, start building relationships, explore the priorities of each entity, and agree on the purpose and identity of a network. At the core of successful CBO networks has been a neutral convener with the skill to “lessen competition among CBOs and increase collaboration.”

This neutral convener will need to be skilled at facilitation, brokering cross-sector relationships, and understanding power dynamics among network partners, and will help move relationships from competitive to collaborative. A neutral party can help identify the key functions and responsibilities of the network, define the services that each partner CBO will provide, and establish a mutually agreed upon governance structure.

“These are not transactional relationships, they are transformational, which means you have to dedicate the time and resources to ensure they are successful.”

— CBO network representative

Brokering and negotiating on the above, however, takes a significant amount of time but is critical to building trust and understanding among partners. Supporting and scaling networks already in existence — for example, the Accountable Communities of Health (ACH) — builds on established trust among partners and may help to lay the groundwork for partners to formalize network functions and capabilities. California’s ACH sites bring together a diverse range of partners to address the constellation of community health and social needs, and include neutral conveners such as local health departments, CBOs, and community organizing entities. Recognizing the success and potential of the ACH model, in June 2022, Governor Gavin Newsom approved a \$15 million budget line item that will support the expansion of ACHs to 25 new sites throughout the state.¹⁵ Interviewees noted that building the capacity of existing ACHs and creating additional sites will create the needed

infrastructure for MCPs to partner with communities to deliver whole-person care services, such as ECM and CS, as well as partner on other programs and initiatives designed to improve population health.

Additionally, CBO informants shared perspectives that MCPs are behemoths, “a little opaque,” and can be disconnected from the very vulnerable populations that CBOs typically serve. CBOs representatives also cited “informational asymmetry” with MCPs, with MCPs holding all the information on program requirements, contracts, and reporting standards, which has created a challenging dynamic for CBOs to get information and move processes forward. Differing lexicons for service delivery and reimbursement were also cited, including different measures of success, which makes developing and navigating partnerships difficult. An NLE could help CBO partners navigate this information challenge, provide some translation

San Diego Wellness Collaborative: A Backbone Across Initiatives

Neighborhood Networks has been operating as a network since 2019. Health care organizations and MCPs can contract with Neighborhood Networks to deliver ECM and CS, as well as other programs focused on addressing health-related social needs. Neighborhood Networks leverages the power of “neighborhood navigators” employed by CBOs that have developed deep, trusting partnerships and understand the local assets and barriers to health in the communities they serve.

As a network, Neighborhood Networks utilizes one standardized case management and claims system, ensures CBO partners are compliant with MCP data and security requirements, and assumes responsibility for contracting and reporting, as well as providing education and training to community-based workforces. CBOs who are contracted in the network receive a cost-based reimbursement from Neighborhood Networks with the opportunity to move to incentive-based payments.

Neighborhood Networks is a part of the San Diego Wellness Collaborative, a nonprofit organization seeking to improve population health and to advance equity in San Diego through three major multistakeholder collaborative initiatives. SDWC serves as the lead entity for San Diego’s Accountable Community for Health (SDACH) program, part of the broader California Accountable Communities for Health Initiative (CACHI), which uses a cross-sectoral approach to address clinical and nonclinical needs. SDACH has convened over 100 local leaders to “flip the script” and adopt a collaborative approach that prioritizes community well-being over treatment. The first priority for SDACH was to address cardiovascular health across the lifespan through “Be There San Diego” — a coalition of patients, communities, and health care systems working together to prevent heart attacks and strokes. Through years of partnership and collaboration with community and clinical providers, as well as community members, SDWC has established itself as a trusted entity that was helpful in forming the network.

on MCP processes (e.g., reporting), and advocate on behalf of CBOs and their clients to ensure fair contracts. An NLE could help manage the delegation of services and subcontracts within a network to ensure well-suited CBOs are delivering a particular service, assume responsibility for sharing best practices, align standards, and assure integrity in quality reporting — all of which are critically important in demonstrating value and effectiveness of services delivered. CBO representatives also suggested that an NLE could support training and education of network partners through learning collaboratives, technical assistance, and peer-to-peer exchanges to ensure the spread of best practices and to support the success of a diverse set of CBO types (see box below).

5. Putting Equity at the Center

Many interviewees expressed concerns that factors related to structural racism will likely persist during the rollout of CalAIM, exacerbating existing health inequities unless these issues are deliberately addressed — with input from CBOs and community members. Interviewees cited fears that multisite and well-resourced CBOs will be better positioned to join forces to contract with MCPs, leaving smaller, more locally focused CBOs, which often exclusively serve communities of color, at a disadvantage. Respondents noted that having structures and requirements in place to ensure diversity among CBO type and populations served will be important to ensuring equity. Some states, such as North Carolina, have implemented a checklist for health plans to ensure diversity of CBOs participating, including those led by people of color, in state initiatives (see box below).

Ensuring Equity in North Carolina’s Healthy Opportunities Pilot

North Carolina’s Healthy Opportunities Pilot, the state’s Medicaid 1115 waiver program, is centered on addressing upstream social determinants of health such as food insecurity, transportation, interpersonal violence, and unstable housing. A core component of the pilot is NCCARE360, a statewide electronic platform that connects health and human service providers and supports links to CBOs to address social needs. NCCARE360 includes a call center with (1) dedicated navigators; (2) a data repository to integrate resource directories across the state; (3) a shared technology platform that enables health and human service providers to send and receive secure electronic referrals, communicate in real time, and track outcomes; and (4) a community engagement team working with CBOs, social service agencies, and health systems throughout the state.

As part of the pilot, the state’s managed care organizations, or Prepaid Health Plans (PHPs), will be responsible for developing networks of CBOs. These networks will be established and overseen by a Lead Pilot Entity (LPE), and social services providers interested in participating in a pilot will need to contract with the LPE in its geographic region. As part of the contracting process, the LPE will assess CBO readiness and qualifications to participate in pilot activities. An analysis of the initial wave of CBOs revealed that larger, more experienced CBOs were the first to apply to contract with LPEs, and smaller, less-resourced providers were not at the table. To ensure diversity among contracted CBOs, North Carolina’s Department of Health and Human Services (DHHS) has implemented a review process to ensure adequate representation of CBOs led by women or people of color within each network, and that LPEs and CBO staff are demographically representative of the Medicaid populations in their region. As part of the pilot, DHHS and the LPE will also provide technical assistance and education aimed at human services organizations in pilot areas to ensure their success, and contracted CBOs will be required to participate in these readiness activities and trainings. Capacity-building funds are available to the LPEs to support these efforts, and it is hoped these funds will address equity concerns and ensure that the less-resourced CBOs will benefit from such opportunities. DHHS is currently exploring additional incentives for PHPs to increase diversity among organizations.

Moreover, as the health care landscape shifts and private equity firms focused on profits enter the health care space, there are concerns that the interests and values of smaller CBOs and those serving people of color will be overlooked. Several informants noted that for-profit entities are now working to deliver services, such as medically tailored meals, and while they are “efficient,” their size and distribution range makes them more affordable partners than local nonprofit CBOs. Interviewees cautioned that health equity may not be in the “hearts and minds” of for-profit entities that serve as CBO NLEs, and as networks are established and MCPs begin to partner with them, attention to their connections with community will be important.

6. PATH Funding May Support CBO Network Development

All informants spoken with noted that significant up-front financial and technical support are required to stand up CBO networks. This backing includes financial resources to support staff time to convene and coordinate CBO network roles and responsibilities, to implement infrastructure enhancements (i.e., links to electronic health records and updates to IT systems), and to train staff — as well as technical assistance to meet reporting and billing requirements, new workflows, and understanding CalAIM benefits and programs. Most CBOs operate on a shoestring budget, which limits their bandwidth to make space for these coordinating discussions. Without financial and technical support, the up-front work required by CBOs to form networks and successfully contract with MCPs will feel extractive. PATH (Providing Access and Transforming Health) funding available through CalAIM will be a critical source of support to build, maintain, and scale the capacity necessary to implement ECM and CS statewide.¹⁶ PATH funds could be allocated toward peer-to-peer learning opportunities on CBO network functions and operations, offering “meeting space” for CBOs to form and deepen partnerships, and technical assistance to organizations with an interest in serving as NLEs. Interviewees noted that seed funding, either through PATH or from philanthropy,

could support CBOs to build relationships with one another and to chart a course to collaborate on CalAIM initiatives. As evidenced through the ACH initiative, communities and CBOs are in various states of readiness, and funding to initiate conversations about needs and priorities could support collaboration on a shared goal and vision.

7. Existing California Networks and Lead Entities Can Be Leveraged to Support CBO Network Development

Though California CBO networks are still quite nascent, an array of social services networks and population health-focused conveners and coalitions already exist across the state (see list of examples on page 12). These organizations and coalitions have relationships, skills, and expertise that could be built upon to accelerate CBO network formation. For example, 13 CACHI lead entities have invested significant time convening local health and social services stakeholders, building relationships, creating a shared vision, and understanding the priorities of participating entities. While the CACHIs may not currently perform core CBO network functions, their significant up-front relational investments could be built upon to bring CBOs together and develop some, if not all, network functions. Likewise, organizations such as local United Ways provide a range of health, educational, and financial services in addition to operating or providing funding for 211 programs in 32 California counties. They could be supported to evolve into broader CBO networks, as the example of United Way of San Joaquin illustrates.

There are a few key considerations to leveraging existing infrastructure. With health equity and racial justice in mind, investments in existing partnerships or organizations would need to be deliberately structured so as to prioritize network development inclusive and supportive of CBOs led by people of color. And while CBO network functions may not ultimately align with the long-term role that existing coalitions, conveners,

and networks wish to play, they could be helpful mentors and technical assistance providers to other organizations interested in building this capacity and developing a network.

Examples of Networks Led by CBOs Operating in California with CalAIM (Community Supports and ECM) Alignment

California Accountable Communities for Health Initiative (CACHI)

California Area Agencies on Aging

Community Health Worker Agencies

- ▶ **El Sol**
- ▶ **Visión y Compromiso**
- ▶ **Latino Health Access**
- ▶ **Transitions Clinic Network**

Community clinic consortia

Connected Community Network

California Food is Medicine Coalition

Health center-led IPAs

- ▶ **Community Health Center Network**
- ▶ **Health Center Partners of Southern California**

Health Information Exchanges

California Continuums of Care

Institute on Aging

North Coast Health Improvement and Information Network

Neighborhood Networks

Partners in Care Foundation

Pathways Community HUB Institute (San Joaquin)

Regional Asthma Management and Prevention

United Ways of California

- ▶ **United Way 211 programs**

Conclusion

CalAIM has enormous potential to transform Medi-Cal to be more person-centered, whole-person focused, and equitable. As MCPs look to community-based organizations to help deliver both Enhanced Care Management and Community Supports, CBO networks are a potential model to provide some efficiencies for both MCPs and CBOs. A network lead entity can streamline contracts for MCPs across myriad CBOs, as well as offer technical and translational support to CBOs as they enter the health care space. That said, significant time and resources, along with a trusted neutral convener, are required to ensure the success of a CBO network model. Opportunities within CalAIM, including through PATH funding, could spur connection and new relationships among CBOs and help to build the capabilities of entities able and interested in serving as the neutral convener.

About the Authors

This brief was prepared by Anna Spencer, MPH, senior program officer, and Isabel Clemente, MSW, program associate, at the **Center for Health Care Strategies**. CHCS is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. CHCS works across sectors and disciplines to connect people and ideas to spark insights, build expertise, strengthen leadership, and spread innovations. CHCS focuses on making more effective, efficient, and equitable care possible for millions of people in the US who face serious barriers to well-being, like poverty, complex health and social needs, and systemic racism.

About the Foundation

The **California Health Care Foundation** is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Endnotes

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15. California Accountable Health for Communities Initiative, “**Governor Newsom Gives Stamp of Approval to Groundbreaking Community Health Initiative**” (PDF), press release, June 30, 2022.
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Appendix. Interview List

CHCS conducted interviews with the following key informants in May and June 2022.

Abode Services

Vivian Wan, Chief Operating Officer

Kara Carnahan, Vice President, Programs

California Accountable Communities for Health Initiative

Barbara Master, Director

California Food Is Medicine Coalition

Ann Thrupp, Director

California Pan-Ethnic Health Network

Cary Sander, Senior Policy Director

Camden Coalition of Healthcare Providers

Victor Murray, Senior Director, Community Engagement and Capacity Building

Natasha Dravid, Senior Director, Care Management and Redesign Initiatives

CommonSpirit Health

Ji Im, Senior Director, Community and Population Health

EngageWell IPA

Kevin Muir, Former Executive Director

Local Health Plans of California

Linnea Koopmans, Chief Executive Officer

MassHealth

Gary Sing, Senior Director, Strategic Initiatives

Tamara Lange, Director of Community Partners Program

Stephanie Buckner, Deputy Director of Social Services Integration

Allison Rich, Senior Manager of Social Services Integration

Nonprofit Finance Fund

Annie Chang, Vice President

Alexandra Chan, Director

North Carolina Department of Health and Human Services

Amanda VanVleet, Associate Director of Innovation

Erika Walsh, Director, Healthy Opportunities

Project Access Now

Carly Hood-Ronick, Executive Director

Stephanie Marson, Director, Programs

San Diego Wellness Collaborative — Neighborhood Networks

Kitty Bailey, Chief Executive Officer

Social Current

Ruby Goyal-Carkeek, Senior Vice President, Programs and Services

United Way of San Joaquin County

Kristen Birtwhistle, President and CEO