

# How do Community Health Centers Pay for Social Care Programs?

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Report Commissioned by the Center for Care Innovations

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Social Interventions Research & Evaluation Network

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## Acknowledgements

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Our mission is to catalyze and disseminate high quality research that advances efforts to identify and address social risks in health care settings.

SIREN projects are focused on:

- Catalyzing high quality research to fill evidence gaps;
- Collecting, summarizing, and disseminating research resources and findings to researchers and other industry stakeholders;
- Increasing capacity to evaluate SDH interventions by providing evaluation, research, and analytics consultation services to safety-net and mission-aligned health systems.

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## Executive Summary

As the evidence demonstrating that social and economic circumstances shape health outcomes and costs mounts, health care systems are increasingly investing in activities to mitigate patients' adverse social risks as a routine part of health care delivery. Hardly a day goes by without a new health care brief, report, paper, or conference announcement that highlights the importance of addressing social context as a strategy for preventing disease and improving health. Many hospitals and health care systems are now innovating at this intersection.

Though social determinants of health (SDH) are currently in vogue in new places within the US health care delivery sector, they have always been part of the mortar of the community health center movement. Community health centers were established in the 1960s as one of the War on Poverty programs. They now comprise a core part of the safety-net for low-income Medicaid and uninsured populations. Earlier work has emphasized the importance and extent of social care activities in the community health center context. To date, relatively little work has explored how different kinds of community health centers financially support these activities.

With support from the Center for Care Innovations, we undertook this project to better understand the innovative ways in which community health centers braid different funding streams to implement and sustain SDH programming. To do that, we reviewed the existing literature on health center financing; interviewed over 30 experts from federal, state, and local levels, including from government, hospital and health care systems, non-medical community-based organizations, and community health center leaders; and interviewed leaders from four health centers in diverse areas of the US that are actively engaged in different kinds of social determinants programming.



We learned about the great variety of ways in which community health center innovators initiate and sustain social care programs, as well as the many barriers they face in that work. They leverage funding in patient revenue streams, apply for a surprising number of time-limited grants, and are constantly on the lookout for non-traditional revenue-generating opportunities, like social enterprises. In this brief, we describe approaches that

relate to prospective payment rate adjustments; Medicaid Administrative Activities claiming; Targeted Case Management, Chronic Care Management, and Behavioral Health Integration program billing; patient-centered medical home certification; and new value-based payment opportunities that can be leveraged within—or sometimes



alongside—Medicaid managed care and accountable care organization contracts. We also highlight the impressive range of grant proposals written and awarded.

In each report section, we also describe the looming challenges of each funding strategy. The consequence of those challenges is that community health centers' social care programs are regularly threatened with funding gaps and shortages. Funding received from patient revenue or grant sources is typically less than the degree of patient need. Often funds are restricted to special complex care populations or target age groups. Even when there is more flexibility, other obstacles arise related to grant cycles, grant duration, and funder preferences, which all influence access and sustainability. The human and financial capital community clinics and health centers (CCHCs) spend on identifying funding sources, writing grant proposals, and reporting activities to different funders strongly limit sustainability. Clinics operating outside the prospective payment system and/or without federal grant funding face additional obstacles to supporting their social care programs.



We hope that this report serves two purposes. First, for community health center leaders, it may spark ideas about strategies to support existing or new programs. For policy-makers and advocates, it ideally will also shed light on ways we might change the existing system so that community health centers can continue to provide the services that science increasingly suggests are necessary to meet the needs of patients facing socioeconomic barriers to health. Ultimately, to improve the capacity of CCHCs to provide social care will require not only more funding but more funding stability. The most promising future sources of revenue lie in Medicaid-related programs. New opportunities around value-based and risk-adjusted payments are likely to expand as the Centers for Medicare and Medicaid Services' work develops in this area. In the meantime, CCHCs hoping to expand social care services will continue leveraging the wide range of state innovations; existing value-based care opportunities; federal, state, and local government or private grants; and even social enterprises to initiate and sustain their social care programs.

## Introduction

An expanding literature on the health consequences of socioeconomic adversity<sup>1-3</sup> has influenced health care organizations across the US to experiment with ways to address social risk factors as a strategy to improve health.<sup>4</sup> This experimentation has included a wide range of health care-based activities, from activities related to identifying social risks and coordinating existing social services to activities where social services—like legal services, financial counseling, and food or housing supports—are delivered through the health care system itself.<sup>5</sup>

To accompany this growing experimentation, a national dialogue has emerged about how to utilize health care dollars to initiate and sustain social determinants-related activities—whether the coordination of care or provision of social services. In large part, this conversation has focused on whether and when Medicaid intermediaries (including state Medicaid agencies, Medicaid managed health plans, and accountable care organizations) have authority to pay for them. The emphasis on Medicaid derives from the fact that by design Medicaid serves a large proportion of the US low-income population that would maximally benefit from social and medical care integration. The existing reports on this topic are not exclusive to Medicaid opportunities, however. They also review ways Medicare—and now Medicare Advantage—might support social care coordination or services,<sup>4,6-10</sup> and to a lesser extent, the potential financial return on investment to local and commercial health care organizations if they opt to fund social service programs.<sup>11</sup>

Funding for social care is unique in the context of community clinics and health centers (CCHCs). CCHCs often care for the most socioeconomically vulnerable in the

### What are Social Determinants of Health?

In this issue brief, we rely on the World Health Organization definition of Social Determinants of Health (SDH): “the conditions in which people are born, grow, live, work, and age.” There is a subset of SDH that have been incorporated into existing social risk factor assessment tools (e.g., from the National Association of Community Health Centers and the Center for Medicare and Medicaid Innovation) that include select financial or socioeconomic risk factors—such as food security, housing security, transportation access, utilities security—that are generally considered highly actionable in the context of health care delivery settings.

Using a definition modified from the Center for Health Care Strategies, we define the coordination of non-clinical interventions and services intended to address social risks to include: (1) screening patients for social risks and determining appropriate organizations/agencies with the resources and knowledge to address their specific needs; (2) connecting patients with these resources to help address their social risks; (3) following up to ensure patients are connected and facilitate completion of the social risk intervention or activity; and (4) tracking outcomes of patients receiving social risk-related services.<sup>5</sup>

US and have strong comprehensive care roots.<sup>12</sup> Supported in the 1960s as one of the War on Poverty programs, CCHCs were designed to provide access to community-responsive health and social services for disenfranchised populations.<sup>13</sup> They have continued to comprise a core part of the safety-net for low-income Medicaid and uninsured populations. In 2017, CCHCs provided health care in over 10,000 clinical locations to nearly 28 million people throughout the 50 states, the District of Columbia, and the US territories.<sup>14</sup> Ninety-two percent of CCHC patients are under 200% of the federal poverty guidelines (earn less than \$51,500 for a family of four [2019 figures])<sup>15</sup> and CCHCs serve 1/3 of all the people living in poverty in the US.<sup>16</sup> Based on an inspiring history that has wed community economic opportunity with the delivery of medical care, CCHCs have been steady and strong leaders in health care-based initiatives to identify and intervene on patients' social adversity.<sup>17-19</sup> Earlier work has emphasized the importance of these social care activities in the CCHC context—often referred to as enabling ser-

In this brief, we use “community clinics and health centers” (CCHCs) as an umbrella term covering several different clinic designations, including federally-qualified health centers (community clinics, migrant health centers, homeless clinics, and public housing clinics), look-alike clinics, and non-federally-funded health centers. In select places, we distinguish between these clinic types when specific funding opportunities or restrictions apply.

—as well as the extent of services delivered.<sup>20-26</sup> Despite this commitment to addressing non-clinical needs, CCHCs rarely obtain funding that entirely covers related services, let alone the needs of the populations they serve.<sup>25,26</sup> In this brief, we describe a wide range of funding sources CCHCs currently braid to support efforts to implement and sustain SDH programming, highlighting examples from four specific health centers in different regions of the US. We also present potential obstacles related to the use of each funding mechanism.



### Data Collection Methods

We reviewed the existing literature on health center financing with the goal of exploring strategies that health care systems do and could employ to pay for SDH-related programs. We simultaneously interviewed over 30 experts from federal, state, and local levels, including from government, hospital and health care systems, non-medical community-based organizations, and CCHCs from across the US to better understand

the nuances of different funding sources. Those experts recommended we talk with health center executives innovating in this space. Based on their recommendations, we selected four health centers in diverse areas of the US that are actively engaged in different kinds of social determinants programming. We interviewed leaders in those organizations to more deeply explore the opportunities and barriers they experience on the ground in implementing and sustaining enabling services programs.

### Findings

Federally-qualified and look-alike health centers are uniquely reimbursed for care using a federal funding benefit called the cost-based prospective payment system (PPS), which ensures that these health centers receive pre-determined rates for services provided to Medicaid or Medicare beneficiaries (each program has its own rate calculation),<sup>12</sup> regardless of contracts with managed care entities or other payers. This means that these health centers continue to operate primarily in a fee for service environment rather than a value-based care one, despite the more general movement towards value-based care models in other parts of the US health care sector. Though over 21 states have adopted alternative payment methodologies (APMs) to facilitate transitions to value-based models for preventive care, federal law mandates that for federally qualified health centers (FQHCs), APMs still ensure payments that are at least equal to payments established under PPS,<sup>27</sup> effectively maintaining the historical fee-for-service structure.



Under traditional fee-for-service models, however, federally-funded health centers have fewer explicit financial incentives to broaden services to include the integration of social care coordination and services beyond what they are required to offer as part of their health center designation (in cases where federal funds are received). While hospitals and integrated health systems may experiment with social services because they are increasingly held accountable for outcomes they believe

will be improved by addressing social risk factors, federally-funded health center financing does not offer a precisely parallel incentive. Similarly, though non-federally funded health centers do not get paid through PPS rates, many nonetheless continue to operate in a largely fee-for-service environment that does not reimburse for food, housing, legal services, or other wraparound social services like care coordination.

In reviewing the potential adoption of social care coordination and services in CCHC environments, it is relevant to note that both federally funded and non-federally fund-



ed CCHCs operate on very thin margins, substantially smaller than those in many hospitals or other health systems.<sup>28</sup> Operating revenues come from two major sources: patient service revenue (on average approximately 60% of total operational funding for clinics receiving federal funding) and grants and contracts (approximately 35% of total operational funding for clinics receiving federal funding). A much smaller category of revenue (3-5%) can come from donations and/or fees, like rental income,<sup>28</sup> though this category is not relevant to all CCHCs.

We focus this report on strategies that CCHCs use to support social care coordination and service delivery using each one of these revenue categories: patient revenue, grant revenue, and other revenue. Our emphasis is on how CCHCs can pay for social care coordination and services, specifically, not how they can more generally increase revenue or grants to support all operations. We assume that most CCHC leaders are already very expert in increasing the number of patients and maximizing revenue earned from both patient visits (like efforts to improve billing and claims processes) and grants.

*“The structure of funding has been organized more towards a traditional medical model, which makes it harder to implement innovative programs that get to the community.”*

*– Noha Aboelata, MD*

### Reimbursement and Incentives for Social Care Coordination and Service Delivery

Efforts to increase patient revenue focus largely on Medicaid enrollment since Medicaid is the largest single source of patient revenue for CCHCs. Additional patient revenues come from Medicare, other public programs, private insurance, and self-pay patients. The large proportion of total revenue from Medicaid derives in part because Medicaid patients make up a large proportion of health center patients (49% as of 2016). Additionally, PPS reimbursement rates for Medicaid patients are high; for CCHCs under the PPS system (FQHCs and look-alike clinics), reimbursements from the PPS are calculated based on total patient costs, not solely the costs of Medicaid patients.<sup>25,28</sup>





Under the Affordable Care Act (ACA), expansion states have dramatically increased the number of Medicaid enrollees. Even in non-expansion states, Medicaid coverage has increased, in part because of increased outreach and enrollment activities. For CCHCs, the increased Medicaid revenue has enabled many health centers to supplement funding for non-clinical activities, including activities like improving information and technology systems and adding system-wide quality improvement initiatives. Improved efficiency and quality from those investments in turn has helped health centers earn even more patient care revenue. In many cases, the result is that the ACA itself has generated new—and in some ways unanticipated—revenue that health centers did not have pre-ACA. Some CCHCs elect to spend this new money on hiring social care staff and offering specific social services.



Beyond the ACA, CCHCs are increasingly incorporating other strategies for outsourcing services, maximizing partnerships, and restructuring payment models—including by leveraging independent practice associations, management service organizations, partnerships with hospitals or managed care organizations, or even mergers with other CHCs.<sup>29</sup> These strategies also offer broad opportunities to increase total revenue and decrease costs, which may help CCHCs support and sustain some non-clinical services.

Beyond these very general approaches to maximizing patient revenue and decreasing costs, CCHCs also have leveraged other opportunities to increase reimbursements and incentives that are more specific to social care. We describe these opportunities in the sections below.

### *Adjust Prospective Payment System Rate*

In FQHCs and look-alike clinics, Medicaid and Medicare PPS rates are applied to reimburse visits that have been deemed eligible by Center for Medicare and Medicaid Services (CMS) or by state Medicaid agencies. With few exceptions, care visits with non-licensed staff—including care coordinators—are not eligible, reimbursable visits. As a result, CCHCs must use other mechanisms to pay for these services. One option for health centers to cover social care costs is to request a PPS rate adjustment that incorporates the cost of staff who provide that care. The PPS is a rate floor determined by an original encounter rate established based on costs incurred in FY 1999 and FY 2000 (or when a clinic opens); that original rate is adjusted annually based on an inflation index used by CMS, and can be affected by changes in scope of clinical

services, such as new or improved facilities or new Medicare or Medicaid-eligible services different from when the base rate was initially determined.<sup>30</sup> When adjustments are made in the PPS rate, clinics can build in the salaries of staff who offer social care coordination or services. There are barriers to using this strategy, including:

- Many states either have no defined process for scope of services rate adjustments or no clear definition of what will constitute a change in scope of services that would trigger rate adjustment;<sup>31</sup>
- Medicaid rules, specifically, are very state-dependent. Each state has regulations restricting how often and when an adjustment is triggered;
- An enhanced PPS rate can only be billed for certain provider-based visits;
- Any rate adjustment request could theoretically result in a rate decrease, which can be a disincentive to requesting revisions.

### *Maximize Medicaid Administrative Claims*

Most CCHCs already have established initiatives to maximize Medicaid enrollment (e.g., eligibility specialists and outreach workers); in expansion states those efforts have been even more pronounced due to opportunities afforded by the ACA. In some cases, health centers use Medicaid Administrative Claiming (MAC) as a strategy for hiring and supporting staff that provide a range of social services. MAC provides matching federal money for every locally-raised dollar spent on select services that contribute to the “efficient and effective administration of Medicaid.”<sup>32,33</sup> Examples include outreach and enrollment, case management, provider monitoring, planning and development, training, auditing, quality improvement, person-centered counseling, program management, and reporting. MAC offers a win-win: it increases enrollment in Medicaid, which thereby increases the pool of patients with the highest revenue for CCHCs; it also directly pays for services involved in administering Medicaid, including costs of referral and coordination services related to Medicaid-covered services. Though claims can only be submitted for Medicaid patients, staff offering these services may be able to work with a broader population.

### **Limitations of MAC**

- Involves local tax or philanthropy dollars given to a certified public agency (which enables it be counted as a Certified Public Expenditure) to obtain federal match (matching rate of \$.50 from federal sources/local dollar), though rates are higher for Medicaid expansion population in some states;
- Administrative burden of time-based billing;
- Claims can be denied or reduced during the state’s auditing process;
- Limited to select services for Medicaid or Medicaid-eligible clients.

**Roots Community Health Center** opened in 2008 with the goal of supporting persons impacted by “systematic inequities and poverty.” Based in East Oakland, California, Roots focuses on providing medical services, job training, and care management. As Roots founder Noha Aboelata, MD explains: “Our model is the model of whole health...But...you need more than doctors to improve health in the community or population.” Roots has placed a strong emphasis on health navigators (1/3 of total staff) to help fulfill its mission of population health. Navigators provide a combination of benefits enrollment, outreach work, and patient navigation services. Funding for these positions has come from a wide range of sources, including:

- California Public Safety Realignment [AB-109]. The bill was designed to support persons recently incarcerated with re-entry into the community.
- Alameda County Measure A. This county bond measure provides funding for programs supporting low income, uninsured residents of Alameda County.
- HealthPAC. This county program relies on the state’s 1115 Waiver to draw down money from the federal government.
- Health Care for the Homeless. This county program works through a federal Health Resources and Services Administration (HRSA) grant to support homeless and marginally housed individuals.
- Oakland City Bond Measure Z. This city measure focuses on violence prevention and support for at-risk youth.
- Community Services Block Grant - Department of Health and Human Services Office of Families and Children. This federal program provides grants to alleviate poverty and support low income families. Of note, these grants can be used for housing.
- Medicaid Administrative Claims program. (See MAC section above).
- Targeted Case Management through Medicaid (See TCM section below).
- California 1115 Waiver for Whole Person Care pilot programs. This Medicaid waiver broadly supports better integration of medical, behavioral health, and social care services in approved cities and counties of California.

At Roots, this range of agencies and funding sources support different community navigator positions. While their training and work overlaps, each navigator’s target group differs (e.g., homeless community members, recently incarcerated, at-risk youth, hepatitis C patients).

## *Bill for Targeted Care Management Services*

Some CCHCs take advantage of Medicaid Targeted Case Management (TCM) programs to fund social care programs. TCM “transcends Medicaid reimbursable care and services” by covering the costs of providing added assistance to specific groups of individuals—like populations on probation or parole—or to individuals living in specific geographic regions.<sup>34,35</sup> Examples of the kinds of services covered under TCM include those related to developing care plans and making program referrals to enable the patients eligible for TCM services to access medical, educational, or social services. TCM is billed through state Medicaid agencies.

### **Roots Clinic & Federal Matching Programs**

One way the Roots Clinic funds its work is through identifying programs that can leverage federal dollars. These programs—Targeted Case Management, Medicaid Administrative Dollars, and SNAP Employment and Training—involve federal matching funds for locally-raised dollars. “We take our local dollars and we’re able to stretch them around the block a few times by using them as leverage,” noted Roots founder, Dr. Noha Aboelata.

### **Limitations of Targeted Case Management Program**

- Requires a local match; matching rate between \$.50 and \$.90/dollar spent, though rates are higher for Medicaid expansion population in some states;
- Not all counties participate in TCM claiming;
- Administrative burden of time-based billing;
- Claims can be denied;
- Case management services are only offered to specific Medicaid populations;
- TCM does not cover the actual provision of services (e.g., legal services).

## *Obtain Patient-Centered Medical Home Status*

Many CCHCs have opted to become officially “certified” or “recognized” as Patient-Centered Medical Homes (PCMH).<sup>36</sup> These certification systems require strategies for coordinating care with community services. This includes strategies for collecting information about SDH and implementing care interventions based on those data (Knowing and Managing Your Patients Competency A07) and maintaining and assessing the usefulness of community support resource lists so that practices can guide patients to community resources that can help support health and well-being (Knowing and Managing Your Patients Competency 26 & 27).<sup>37</sup> PCMH certification can result in increased reimbursement or other incentive payments from select payers.<sup>11,38</sup>

### **Limitations of PCMH**

- Not all payers increase reimbursements or provide incentives based on PCMH



- status (e.g., Medicare or Medicaid patients);
- Despite the promise of increased revenue, some clinics invest more in PCMH than the ultimate financial return from added billing or incentive payments associated with PCMH status.

### *Leverage Medicaid Managed Care Health Plan & Accountable Care Organization Innovations*

Prior work has noted that CCHCs with more managed care contracts provide more enabling services, which includes services related to social care.<sup>39</sup> Medicaid managed care and Accountable Care Organizations (ACOs) are increasingly incorporating SDH-related services that can affect contracts with provider organizations, including health centers.<sup>4,6</sup> These sometimes involve add-on (exceeding PPS rate) per member per month (PMPM) rates to provide specific social services. That additional rate then can enable health centers to hire social care staff or provide specific social needs-related services. The degree to which these value-based programs affect health centers is influenced by state-specific rules about PPS, since health centers need to ensure that payments from such arrangements are not counted as regular Medicaid reimbursements in state reporting.

CCHCs also can enter into *Pay for Performance* or *Pay for Success* agreements with Managed Care Organizations (MCOs) and ACOs to support specific social determinants-related screening or service outcomes (e.g., by increasing food security screening rates). These programs typically do not focus on select populations but rather on achieving specific health outcomes. Payments under these value-based programs are outside of the PPS system. For instance, if a health center improves on a select outcome for a population of patients, it may receive a bonus payment from the managed or accountable care organization outside their PPS and not included in the annual reconciliation with the state (where the state makes any additional payment not covered by managed care entity up to amount expected for all eligible visits under PPS). With the greater focus on Triple Aim outcomes in value-based payment models,<sup>40</sup> both the dollar amount and total proportion of health center revenue from these kinds of programs is likely to increase over time.

### **Social Risk Adjustment?**

In coming years, there may be opportunities to adjust PMPM payments or Pay for Performance or Success agreements using “social risk adjustments,” which would take social risk into account in projecting predicted costs/patient. Currently, the National Quality Forum, the National Academies of Sciences, Engineering, and Medicine, and other agencies are exploring whether social risk should or could be used in these ways. Notably, Massachusetts has incorporated social risk factors into Medicaid reimbursement rates, but not yet into health center PPS rates. To put these payment adjustments into practice in health centers is likely to require additional social risk data collection—and codes to document identified risks—as well as more consensus on how much payments should be adjusted for different risk factors.

In other cases, CCHCs have convinced payers to pool resources to support community health workers or other navigator-level staff in clinical settings to work across the CCHC's population.<sup>41</sup> In these cases, while payments are not directed to the health center, per se, payers nonetheless may help to cover the costs of staff that provide social services in that location.

The **Dimock Center in Roxbury, Massachusetts** is an FQHC that has worked hard to integrate different teams and eliminate operational silos. Their behavioral health, medical care, and social care teams all work under one administration. The clinic leadership currently funds their community health workers with dollars from the state-level Delivery System Reform Incentive Payment Program (DSRIP), a local health commission grant, and a family foundation grant. The clinic's social risk screening activities are now woven into their ACO's quality metrics and will soon be **pay-for-performance. Use of an approved social risk screening tool is now a quality metric throughout MassHealth, so in the near future, all Massachusetts Medicaid providers will have incentives to conduct social risk screening.** Dimock and its funders are also paying for a technology-based resource platform - REACH - which helps the clinic to connect individuals with community resources.

### *Maximize Chronic Care Management & General Behavioral Health Integration Billing*

Another strategy for paying for social care coordination involves leveraging programs targeted to populations with specific illnesses, including multiple chronic diseases and/or mental illness. Like TCM, these kinds of programs involve additional payments that help to cover services provided outside PPS-reimbursable visits, but they are not synonymous with case management services. Chronic care management (CCM) billing requires well-documented, moderate to high complexity medical decision-making and structured care planning for patients with at least two eligible chronic illnesses.<sup>42,43</sup> Typically, CCM is billed initially by advanced practice clinical providers, though in some states can then be directed to non-licensed professionals working under the licensed clinician.<sup>44</sup> Behavioral health integration (BHI) programs bring behavioral health services into primary care for patients with mental illness or advanced behavioral health needs. CMS primarily makes separate payments for BHI programs, which can cover intensive social, mental health, and medical care coordination and patient monitoring services.<sup>45</sup> Both CCM and BHI are programs typically contracted through managed care health plans, ACOs, or with county health departments directly.

#### **Limitations of CCM/BHI**

- Requires explicit beneficiary consent documented in the record;
- Only one practitioner can provide care coordination services in a given month;
- There are very specific patient eligibility requirements.

### Identify Other State Innovation and Payment Reform Programs

Many MCO, ACO, and local health department programs that CCHCs leverage to support social care integration ultimately depend on State Plan Amendments (e.g., Health Homes), Medicaid 1115 waivers, and State Innovation Models (e.g., Comprehensive Primary Care Plus).<sup>46</sup> These programs can authorize CCHCs to qualify for additional per member per month rates or bundled payments. In other cases, they may provide mechanisms through which services can be routed to patients seen in CCHCs, like in the case of Oregon Coordinated Care Organizations flexible funding pools, where money is available to pay for one-time social needs or services, such as a screen door, an air conditioner, or shoes. Some, though not all, of these special programs are specific to chronically ill beneficiaries or other designated beneficiaries, e.g., children with asthma, adults with mental illness, or adults with two or more chronic conditions.<sup>7,47</sup>

**Fair Haven Community Health Care in Connecticut** utilized a state-funded program – Preventive Service Initiative (PSI) – that offers investments for health centers to collaborate with existing community-based organizations (CBOs). This has enabled their clinics to formalize relationships and joint activities with multiple community agencies.

In other examples, CCHCs may leverage the flexibility of state level innovations to support infrastructure investments that can support social service programming. For instance, some state models will fund health centers to send staff to clinical health worker certification programs (State Plan Amendment and waiver in Oregon).

### Limitations of payer and state level agreements

- There is no universal, simple way to discover opportunities to participate in innovation models. CCHC leaders must stay connected to Primary Care Associations, state Medicaid agencies, or consultants who can share information about these opportunities;
- Drawing down on these initiatives requires sufficient CCHC infrastructure to ensure that administrative requirements can be met. Participation also can depend on provider awareness or require active training of CCHC providers. For instance, in Oregon, though flexible service dollars are available to pay for one time social service supports, few providers are sufficiently familiar with the program to recommend it;<sup>48</sup>
- Payment based on performance can put a health center at a high degree of financial risk, which CCHCs are rarely able to assume. It is critical to create risk sharing agreements that match a health center's capability to manage risk.<sup>49,50</sup> Larger or more established CCHCs may be better able to enter into these agreements, though this is irrelevant to FQHCs, which are protected from downside risk by PPS and APM agreements;
- These opportunities are not available in all states or geographies. Many ACO

opportunities, for instance, depend on State Plan Amendments and 1115 waivers that provide new opportunities to spend either Medicaid and Medicare dollars on both social care coordination and services;

- There can be a high administrative burden of participating in payer-led programs;
- These opportunities are often time-limited and may not reappear in future waivers or state plan amendments.

### Grants

The second largest source of operating revenue for CCHCs are grants, including federal, state, and local government grants and private philanthropy. Grants are an essential strategy health centers use to provide more comprehensive services, including care that is not reimbursable.<sup>28</sup>

#### *Health Resources & Services Administration Grants*

For federally-funded clinics, HRSA's Federal 330 and the Community Health Center



Fund (CHCF) (an additional appropriation for community health centers tucked into the ACA) grants on average account for near 20% of total revenue.\*<sup>51</sup> These grants are awarded to health centers to ensure care can be provided to all patients regardless of their ability to pay. They also help to cover the difference between costs and revenue and to enable health centers to offer services that are not otherwise covered under select state Medicaid or Medicare rules or by private payers. Since the primary role of the 330 grant is to cover the cost of care for the un- and under-insured,

there are not always ample HRSA grant funds to support social services.

Health centers qualify for HRSA grants if they both provide medical services regardless of the ability to pay for them and provide “enabling services”, which are non-clinical services that increase access to health care and can improve health outcomes.<sup>26</sup> Though typically not reimbursable and moreover poorly measured and tracked in the

\* The percentage is less in Medicaid expansion states where more patient revenue is available; and more in non-expansion states. It also may differ for homeless, migrant, and public housing clinics, which are eligible for additional HRSA supports.



existing national data, the category “enabling services” has become an umbrella term for many social care coordination and service activities—including programs staffed by community health workers and navigators, some eligibility assistance services, and legal services, which since 2014 have qualified as enabling services. Enabling services costs per patient and per visit have grown by approximately 20% since 2012.<sup>52</sup> Though total HRSA appropriations for health centers have increased since that time, most health center program appropriations have been used to expand the number of health centers or to provide new services; funding to individual centers for operating costs like enabling services has increased less rapidly.<sup>12</sup>

CCHCs can also consider leveraging HRSA’s Health Careers Opportunity Program to subsidize the tuition of students to train to be part of a health centers’ social care workforce.<sup>41</sup>

### Limitations of HRSA grants

- HRSA funding is awarded only to some health centers that have won competitive grants to qualify as FQHCs, including community health centers, homeless clinics, and migrant clinics. Look-alike health centers and other community clinics do not receive Health Center Program funding, though look-alikes are eligible for CMS PPS payments;
- HRSA grant dollars can only be spent in health care and related activities and cannot be spent on items out of the scope of the grant.

### *State and Local Government Grants, Universities, and Private Philanthropy*

Roots Community Health Center also turns to grants for additional support. “So, it’s a real discipline,” Dr. Aboelata described, “We don’t apply for everything. We apply for things that we think we’re going to be able to integrate. So . . . before we even apply for funding, we look at our organizational structure, at where it’s going to fit . . . where it’s going to bolster something that we already have, to add value or fill a gap.”

Since 330 and CHCF grants cannot cover all FQHC programs—and are not accessible to all health centers—most health centers pursue other grant sources to support social care coordination and services. Though some of the larger grant sources may be designated at the federal level, most of these grant funds are distributed and administered at state or regional levels. Together, state, local, and private philanthropy sources comprise

on average 14% of CCHC total revenue and other federal sources comprise less than 2%.<sup>12</sup> CCHCs doing more social care work seem to have identified a surprising number of unique grant opportunities to support their work. Some examples of non-330 or CHCF government-sponsored grants that are being used by CCHCs to support social services like workforce development programs, legal services, and community health worker/navigator programs are included in the list below.

- Community Services Block Grants;
- US Department of Agriculture grants for Supplemental Nutrition Access Program (SNAP) Employment and Training (workforce training program). State awardees often then delegate funds for county distribution;
- HRSA Ryan White Program;
- Department of Labor/Workforce Innovation and Opportunity Act;
- Department of Corrections and Rehabilitation (workforce training program);
- Local health department grants;
- Local university collaborations;
- Private philanthropy.

*“It’s a hodgepodge of funding, but it’s a hodgepodge that we’ve been able to historically pull together to provide some services.”*

*– Michael Tang, MD*

It also is common for CCHCs to braid multiple funding sources to support a single program or staff involved in enabling services. In CCHCs we spoke with, community health worker programs could be supported by more than three funding sources, all with different regulatory requirements. That means CCHC administrative staff might collect different information and submit unique reports on the same program for different grant sources, which carries high administrative load.

### Limitations of grant programs

- Difficult to use for program maintenance;
- Grants often fund innovation rather than ongoing programs;
- Grant cycles do not always parallel clinic funding needs;
- Grants require staff to find, write, and, if funded, administer. Some grants carry substantial administrative burden that may distract from other priority activities.

The **Kokua Kalihi Valley Clinic (KKV)** is an FQHC based in Honolulu, Hawaii. They develop many of their innovative projects by leveraging state, local, and private grants. According to their executive director, David Derauf, MD, MPH the clinic applies annually for over one hundred grants to help support the costs of their robust social determinants-oriented programs. In addition to managing many community-based programs (including a 100 acre nature park) KKV has an on-site Medical Legal Partnership, comprehensive elder care services, and a variety of CHW-run programs. The reliance on grants has enabled flexibility to engage in innovations, but also demands significant staff effort (writing proposals and funder reports) and at times means facing funding uncertainty. Derauf captured the reality of grant-based program funding in explaining: “We scramble and we make crazy and we deal with what we have.”

*“I’ve seen these Requests for Proposals come out where they say we’ll pay for one year, and then we’ll pay a portion of the next year, and then you have to own it, sort of help you make that transition. I didn’t see a lot of those ten years ago - they were like, we’ll give you the money and see how it goes.”*

*- Doug Olson, MD*

### Other Operating Revenue

A small amount of additional operating revenue for health centers can come from sources other than patient revenue and grants. This includes rents when health centers have space to rent, in-kind donations, or sales. In the course of interviews, we learned of specific CCHCs where SDH-related work itself generates new revenue (see Box on Roots CHC below). In these examples, social enterprises enabled the health center to sell new products, but at the same time offered a strategy for vocational rehabilitation or workforce training and development.

### Social Enterprise

**Roots Community Health Center launched the social enterprise Clean360** in 2013 with pilot funding from Alameda County. Clean360 is a social entrepreneurship organization that manufactures soap. As Roots founder Noha Aboelata recalls: “We had been in existence for maybe about two or three years when we really started to put our heads together in a think-tank style about what was keeping our community from being healthy and what could we do about it. And really it just boiled down to poverty being the number one reason why people were unhealthy or unable to become healthy even after engaging with clinic services. And we really felt like we were going to need to do something to directly address it.”

Clean360 targets those who struggle finding employment, including the unsheltered, formerly incarcerated, and others marginalized from the workforce. The program provides onsite job training and sells its soap products for revenue. The initial pilot project was supported by the Alameda County Social Services Agency. As Clean360 has grown, Roots has continued to raise funds from a range of sources, including Community Services Block Grants and the Department of Labor Work Force Innovation and Opportunity Act.

### Limitations of other operating revenue/social enterprise

- Requires substantial initial and ongoing investment in social mission;
- May require spin off as linked taxable entity depending on number of sales.

### Conclusions

In November 2018, Secretary of Health and Human Services Alex Azar spoke to a small audience at the Hatch Foundation for Civility and Solutions in Washington, DC. In his speech, he heralded new federal health policy that he said might offer flexibility to pay for social services with the aim of improving health care outcomes. “What if we gave (health care) organizations more flexibility so they could pay a beneficiary’s rent if they were in unstable housing, or make sure that a diabetic had access to, and could afford, nutritious food?” he asked.

This flexibility - and ideally increased total dollars - would be welcomed by the health center leaders we spoke with, who despite commitment, resourcefulness, and innovation nonetheless struggle to support comprehensive biopsychosocial programming for the populations they serve. These leaders have found innovative ways to braid funding to support social care coordination and social services because they believe these programs improve patient health and well-being and patient and provider satisfaction.

*“We are doing so many things that haven’t traditionally been seen as health by the Western medical system but that are part of traditional health in our community.”*

*– David Derauf, MD, MPH*

In fact, these programs are regularly threatened with funding gaps and shortages. Funding received from patient revenue or grant sources is typically less than the degree of patient need. Often funds are restricted to special complex care populations or target age groups. Even when there is more flexibility, other obstacles arise related to grant cycles, grant duration, and funder preferences, which all influence access and sustainability. The human and financial CCHC capital spent on identifying funding sources, writing grant proposals, and reporting activities to different funders strongly limits sustainability. Clinics operating outside the PPS and/or without 330 funding face additional obstacles to supporting their social care programs.

To improve the capacity of CCHCs to provide social care will require not only more funding but more funding stability. The most promising future sources of revenue lie in Medicaid-related programs—and new opportunities around value-based and risk-adjusted payments are likely to grow as CMS’ work develops in this area. In the meantime, CCHCs hoping to expand social care services will need to continue leveraging the wide range of state innovations, existing value-based care opportunities, federal, state, and local government or private grants, and even social enterprises to initiate and sustain their social care programs.



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## Appendix 1. Community Health Center Profiles

### Roots Community Center

*“The mission of Roots Community Health Center is to uplift those impacted by systematic inequities and poverty by providing culturally responsive, comprehensive health care, behavioral health, and wraparound services; identifying and addressing root causes of illness and suffering; and emphasizing self-sufficiency and community empowerment.”*

Roots Community Health Center was founded in 2008 and is dedicated to “providing high-quality, comprehensive and culturally appropriate health care” in East Oakland, California (<http://rootsclinic.org/history/>). Roots started as a residence-based care program delivering health care to men in various re-entry programs, fatherhood programs, and substance use facilities. They have since expanded to four clinic sites providing pediatric, adolescent, and adult care. They also run a comprehensive street team outreach medical program and provide health care services at Peralta Community College District’s four college health centers. Roots employs various programs to reach at risk community members - those with chronic illness, formerly incarcerated individuals, high-risk youth involved in gang or gun activity, and individuals with HIV and Hepatitis C. The clinic maintains a deep community connection through robust care navigation programs and comprehensive health services. In addition, they established Clean360, a soap-making factory, as a social enterprise to provide on-the-job training and employment opportunities.

### Fair Haven Community Health Care

*“To improve the health and social well-being of the communities we serve through equitable, high quality, patient-centered care that is culturally responsive.”*

Fair Haven Community Health Care based in New Haven, Connecticut, began as a volunteer, school-based clinic in 1971 ([www.fhchc.org](http://www.fhchc.org)). Initially, a small group of volunteers saw patients two evenings a week. Since then, Fair Haven has grown to 14 locations and has nearly 80,000 patient visits a year. The various health centers provide primary care, specialty care, and prenatal services. They have six School Based Health Centers, on-site laboratories, and comprehensive programs to provide support for parenting and chronic disease management.

### **The Dimock Center**

*“Our mission is to heal and uplift individuals, families and our community.”*

In 1862, the Dimock Center was founded as New England Hospital for Women and Children, dedicated to serving women by women. In 1969, the hospital became Dimock Community Health Center, a community-based organization dedicated to providing comprehensive health and human services to Boston’s marginalized communities. Dimock provides adult, pediatric, dental, and eye care services, with fully integrated outpatient behavioral health services. Dimock also offers comprehensive inpatient substance use disorder treatment facilities, including an inpatient detox program, and transitional housing for men, women, and families. In 2016, Dimock cared for 17,000 patients and had 76,000 office visits. More information about The Dimock Center is available at <https://dimock.org>.

### **Kokua Kalihi Valley Comprehensive Family Services**

*“Together we work toward healing, reconciliation and the alleviation of suffering in Kalihi Valley, by serving communities, families and individuals through strong relationships that honor culture and foster health and harmony.”*

The Kalihi Valley community established Kokua Kalihi Valley Comprehensive Family Services (KKV) in 1972. At that time, the community lacked accessible health care services for the Native Hawaiian and Asian and Pacific Islander immigrant population. Formed based on the motto of “neighbors being neighborly to neighbors”, KKV’s first four staff were women from the community who went door to door, listening to the stories of their neighbors. From those stories came dental and medical services in the parking lot of a local church. Today, KKV is a Federally Qualified Health Center, with 210 staff working in nine locations. KKV serves more than 10,000 community members a year and is based in various community settings, including public housing and an elder center. They provide full scope primary care services, care management, transportation, smoking cessation, and chronic disease management. They also run youth empowerment programs, manage a community food hub, and maintain a 100-acre park with organic farming and native reforestation efforts. More information about KKV is available at <http://kkv.net/index.php/about-kkv>.



## Appendix 2: List of Interviewees

We are deeply indebted to the many individuals who shared expertise with us in the process of developing this report. They include:

Nicole Boone, Capital Impact Partners  
Alex Briscoe, Formerly of Alameda County Health Care Services Agency  
Jeremy Cantor, John Snow, Inc  
Rosy Chang Weir, Association of Asian Pacific Community Health Organizations (AAP-CHO)  
Laura Choi, San Francisco Federal Reserve Bank  
Curt Degenfelder, Curt Degenfelder Consulting  
David Derauf, Kokua Kalihi Valley Comprehensive Family Services  
Laura Etherton, Oregon Primary Care Association (OPCA)  
Damon Francis, Health Leads  
Rebecca Gephardt, Alameda County Health Care Services  
Carly Hood, OPCA  
Kiely Houston, John Snow, Inc.  
Michelle Jester, National Association of Community Health Centers (NACHC)  
Doug Jutte, Building Healthy Places  
Jennifer Kavar, Non-profit Finance Fund  
Lynn Knox, Oregon Food Bank  
Rishi Manchanda, HealthBegins  
Rachel Metz, The Tipping Point Foundation  
John Moon, San Francisco Federal Reserve Bank  
Nwando Olayiwola, RubiconMD  
Douglas Olson, Fair Haven Community Health Care  
Michelle Proser, NACHC  
Daniel Ramirez, Capital Impact Partners  
Danielle Sobel, OPCA  
Michael Tang, The Dimock Center  
Sadena Thevarajah, HealthBegins  
Lea Thompsett, Health Leads  
Rachel Tobey, John Snow, Inc.  
Tuyen Tran, AAPCHO  
Ashby Wolfe, Centers for Medicaid and Medicare Services  
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# siren

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