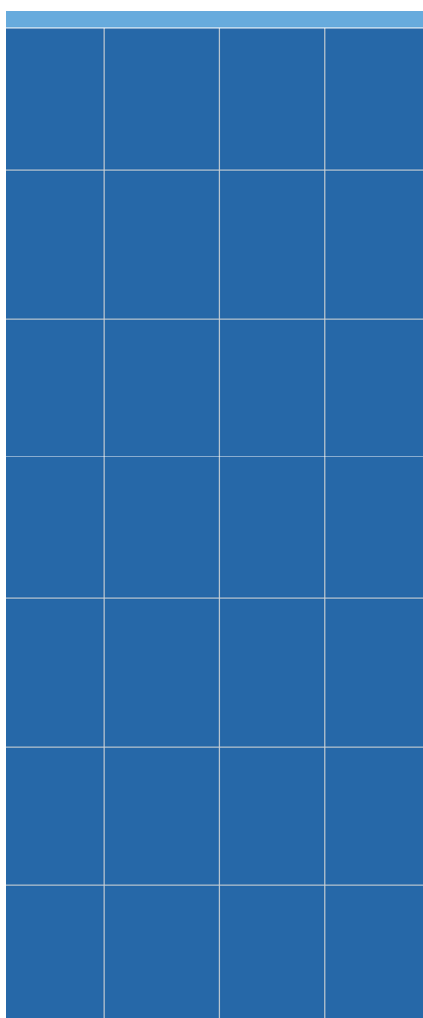


# INTEGRATING HEALTH AND HUMAN SERVICES



The Commission on Value-Based Care





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## ABOUT THE HUMAN SERVICES COUNCIL OF NEW YORK

Founded in 1991, our mission is to strengthen New York's nonprofit human services sector, ensuring all New Yorkers, across diverse neighborhoods, cultures, and generations reach their full potential. We represent New York City's nonprofit human services industry, an economic engine whose more than 200,000 employees deliver services that improve the physical, emotional, and economic health and well-being of individuals and help communities fight prejudice and violence, recover from disasters, and create pathways to opportunity.

The Human Services Council works on many levels, helping member organizations address and meet human services needs more effectively by:

- Acting as the intermediary between the nonprofit sector and government agencies, which provide most of the funding for human services, to propose and advocate for policies and legislation that enhance the delivery of services and promote best practices in how nonprofits contract, report, and get reimbursed for this work.
- Serving as the primary advocate for adequate funding of human services, while simultaneously promoting efficiency on the part of service providers.
- Connecting diverse member organizations with each other, government officials, and the education, healthcare, philanthropy, and business communities, helping them work together more intelligently and collaboratively, leading to greater impact.
- Training nonprofit groups on advocacy and government relations, as well as how to message their work to the media, to increase visibility, attract volunteers, and raise funds in the social media age.
- Ensuring that social, racial, and economic justice issues are a central component of human services policy and delivery and helping individuals, families, and communities who depend on human services to have a voice in public policy decisions that affect their lives.
- Strengthening the sector's role in disaster response by ensuring that nonprofits coordinate with each other on preparedness and with government and foundation funders post-disaster.
- Mobilizing support for tackling the social and economic issues that underlie the growing demand for human services.
- Holding government agencies and elected officials accountable for their commitments to meet the human services needs of all New Yorkers.

HSC has a small staff and budget, but exercises significant clout because it represents a strong and broad-based network of leading organizations in the human services sector. We encourage our members to be active participants in advocacy and to build effective relationships with public officials and the communities they represent. By working together with our 170 members and other allies, we have real impact, bringing people together to solve problems and advocate for policies that let nonprofits continue to serve their communities well.

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## EXECUTIVE SUMMARY

New York's health care delivery system is in the midst of a monumental change. As policy-makers, health care leaders, and other stakeholders across the nation work to transform the delivery of care, New York is among a small group of states that are leading the way with an ambitious initiative aimed at integrating health and human services. In some ways, these two sectors are strangers living next door—working in close proximity but unaware of the details of each other's lives. Both have a direct impact on population health and well-being, but in most cases, these systems work separately. Central to New York's reform effort is the unification of these two sectors in a more comprehensive framework that addresses the complex and myriad factors affecting population health.

Despite spending more on health care than any other industrialized country, the U.S. ranks 11th in overall health outcomes.\* As stakeholders across the nation work to change this reality, New York is leading the way with a bold reform effort centered on the integration of health and human services.

\*Davis, Karen, et al. *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, June 2014, [www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror](http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror)

Compelled by the growing body of research on the impact of social factors on health—and with support in new federal policies—the State is working towards a value-based payment (VBP) structure for health services. This new structure will reward positive outcomes, or value, rather than volume of services provided. A critical element of this transition is the integration of health and human services. In order to achieve the State's "Triple Aim" of better care, better outcomes, and lower cost, State agencies have begun to leverage the expertise of community-based organizations to address social determinants of health as part of a comprehensive, person-centered health care model. This report examines the challenges to effective integration of health and human services and lays out a proposed blueprint for pursuit of the Triple Aim.

### Social Determinants of Health: The Key to Better Outcomes

Social determinants—"the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life"—are a key predictor of health outcomes.<sup>1</sup> They include access to healthy food, reliable transportation, interpersonal relationships, and safe, stable housing. The research on specific determinants is compelling. States and countries with a higher ratio of social-to-health care spending rank better in terms of overall health outcomes.<sup>2</sup> The following examples illustrate the link between specific social determinants and measurable health outcomes.

1 "About Social Determinants of Health." *World Health Organization*, [www.who.int/social\\_determinants/sdh\\_definition/en/](http://www.who.int/social_determinants/sdh_definition/en/).

2 Rubin, Jennifer, et al. "Are Better Health Outcomes Related to Social Expenditure? A Cross-National Empirical Analysis of Social Expenditure and Population Health Measures." *RAND Corporation*, 2016, [www.rand.org/pubs/research\\_reports/RR1252.html](http://www.rand.org/pubs/research_reports/RR1252.html).

Bradley, Elizabeth H., et al. "Variation in Health Outcomes: The Role of Spending on Social Services, Public Health, and Health Care, 2000–09." *Health Affairs*, vol. 35, no. 5, Project HOPE: The People-to-People Health Foundation, Inc., May 2016, [www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0814](http://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0814).

Bradley, Elizabeth H., and Taylor, Lauren A. "How Social Spending Affects Health Outcomes." *Robert Wood Johnson Foundation*, 17 Aug. 2016, [www.rwjf.org/en/culture-of-health/2016/08/how\\_social\\_spending.html](http://www.rwjf.org/en/culture-of-health/2016/08/how_social_spending.html).

- **HOUSING:** It may seem obvious that healthy homes promote good physical and mental health,<sup>3</sup> but housing affordability also has a significant impact on health. Children who live in areas with higher rates of unaffordable housing tend to have poorer health, more behavioral problems, and lower school performance.<sup>4</sup>
- **SOCIAL CONNECTION:** Lonely individuals may be twice as likely to develop the type of dementia linked to Alzheimer’s disease in late life as those who are not lonely.<sup>5</sup> Not surprisingly, “social integration delays memory loss among elderly Americans.”<sup>6</sup>
- **FOOD SECURITY AND NUTRITION LITERACY:** We know that income and geography affect an individual’s access to healthy food. Healthy cooking and eating habits are equally important, but they may be more difficult to develop in low-income areas.<sup>7</sup>

### Community-based Organizations: Architects of Well-being

In New York, nonprofit community-based organizations that deliver human services (human services CBOs) have been addressing social determinants of health for more than a century. They care for children, the elderly, and the disabled of all socioeconomic and cultural backgrounds; provide food, housing, and transportation assistance; and deliver services and supports for immigrants, people with substance use disorders, people experiencing homelessness, individuals involved in the justice system, people with barriers to employment, and socially marginalized groups. Human services CBOs enhance overall well-being by empowering individuals to reach their full potential and enabling communities to thrive. The Human Services Council of New York (HSC) applauds the State for recognizing them as the keystone of a holistic approach to “whole health.”

At the same time, it is important to acknowledge that New York’s vast network of human services CBOs is in distress. State and local governments rely heavily on these organizations to deliver services that directly contribute to health and well-being, but longstanding policies, practices, and funding patterns have undermined the fiscal health of this sector, severely reducing the operating margins necessary to take on risk. A significant number of human services CBOs are insolvent, and many have little to no reserves.<sup>8</sup> Addressing the challenges of financial uncertainty and low tolerance for risk will enable human services CBOs to collaborate more effectively with the health care system in value-based payment arrangements.

3 “Exploring the Social Determinants of Health: Housing and Health.” *Robert Wood Johnson Foundation*, May 2011, [www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2011/rwjf70451](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70451).

4 Jelleyman, T., Spencer N. “Residential Mobility in Childhood and Health Outcomes: A Systematic Review.” *Journal of Epidemiology and Community Health*, 62(7): 584-92, 2008.

5 “Loneliness and Alzheimer’s.” *Rush*, Rush University Medical Center, [www.rush.edu/health-wellness/discover-health/loneliness-and-alzheimers](http://www.rush.edu/health-wellness/discover-health/loneliness-and-alzheimers).

6 Ertel, Karen A., et al. “Effects of Social Integration on Preserving Memory Function in a Nationally Representative US Elderly Population.” National Center for Biotechnology Information, July 2008, [www.ncbi.nlm.nih.gov/pmc/articles/PMC2424091/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2424091/).

7 Apatu, Emma. “P1 Cooking Classes: Are They Effective Nutrition Interventions in Low-Income Settings?” *Journal of Nutrition Education and Behavior*, vol. 2, p. S9, 2016, [www.jneb.org/article/S1499-4046\(16\)30139-7/pdf](http://www.jneb.org/article/S1499-4046(16)30139-7/pdf).

8 *New York Nonprofits in the Aftermath of FEES: A Call to Action*. Human Services Council of New York, 2016 [humanservicescouncil.org/commission-examine-nonprofit-human-services-organization-closures/](http://humanservicescouncil.org/commission-examine-nonprofit-human-services-organization-closures/).

## HSC's Commission on Value-based Care

HSC convened the Commission on Value-based Care to examine and inform the State's health care reform efforts with a human services CBO lens. Over the course of a year, this group of leaders with experience and expertise spanning government, health care, philanthropy, academia, and human services explored areas including social determinant interventions, outcome measurement, the current regulatory, contractual, and financial environment, and human services CBOs' readiness to participate in VBP arrangements. The Commission found that the paradigm shift from volume-driven to value-driven care presents both great opportunity and great challenges for human services CBOs, and that government, as the principal buyer of their services until now, must take decisive action to strengthen these organizations, modernize the regulatory framework within which they operate, and foster cross-sector partnerships that truly incentivize positive outcomes.

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## The Blueprint: Recommendations for Successful Partnership

The reform effort currently underway, the Delivery System Reform Incentive Payment (DSRIP) program, is a bold step in the journey towards the Triple Aim. In fact, the State is a national leader in the implementation of VBP. The Commission strongly supports this policy direction and has identified areas that require further work in order for this vision to be realized. We recommend that the State, in partnership with representatives from human services CBOs and health care industry leaders, lead a process to further develop and implement the following recommendations, which we collectively refer to as *The Blueprint*. For the sustainable integration of health and human services to take place, the following actions are necessary:

### 1. BRIDGE THE TECHNOLOGY DIVIDE

Information technology plays a critical role in promoting collaboration and care coordination, facilitating outcome measurement and reporting, and streamlining payment. Unfortunately, the current landscape is a patchwork of reporting systems that lack interoperability and impede efficient service planning, collaboration, and delivery. In addition, the vast majority of human services CBOs lack the resources to purchase and learn how to use new systems. Strengthening health care information management must begin with a full assessment of systems that are currently in use across all sectors and collaboration to streamline administrative processes through a system that is available to human services CBOs at no charge.

### 2. UNDERTAKE A COMPREHENSIVE REVIEW AND OVERHAUL OF REGULATORY REQUIREMENTS

While the State has moved towards a population health focus that prioritizes outcomes, the legal framework that governs health care and human services has remained largely unchanged, hindering innovation and creating inefficiencies. In many respects, the State is building a value-based health care system on a volume-based foundation. In addition, managed care organizations and New



York State agencies operate largely in isolation, resulting in redundancy in some areas and inconsistency in others. Conflicting or duplicative regulations increase administrative costs, restrict creativity, and discourage collaboration.

Together, all sectors must engage in a thorough review of existing legislation, regulations, and policies to identify those that can be streamlined, amended, or eliminated in order to remove barriers to partnering with health care plans and providers. This process should also include identifying opportunities to standardize reporting among all payers (by commissioning a universal platform), unifying credentialing, and incentivizing coordination of care. Only with comprehensive, strategic regulatory relief and greater standardization can the Triple Aim be achieved.

### ***3. MAKE INVESTMENTS AND BUILD SYSTEMS THAT SUPPORT STRONGER AND MORE INFORMED RELATIONSHIPS BETWEEN THE HEALTH CARE SYSTEM AND HUMAN SERVICES CBOS***

For the collaboration between health and human services to succeed, formal systems must be established for supporting partnerships between human services CBOs and health payers. Health and human services have long worked in close proximity—often with significant overlap—but for the most part, these sectors have worked in isolation. To work together towards the State’s shared goals, they must have some knowledge of each other’s drivers, challenges, strengths, and limitations. Accordingly, learning and networking opportunities to bring the two sectors together must be fostered. The health care system should also be educated on how to craft requests for proposals (RFPs) for human services CBO partnerships.

### ***4. PROVIDE GREATER AND MORE TARGETED SUPPORT FOR ESTABLISHING PROVIDER NETWORKS***

Just as human services CBOs must work with the health care system, they must also collaborate amongst themselves. Collaboration among human services CBOs is more conducive to person-centered, whole health care and allows for better coordination with health care partners to offer inter-related and coordinated services as a continuum of care. Affiliations can increase an individual organization’s capacity for relationship management and contract negotiations, leading to fairer pricing and revenue sharing approaches, more appropriate performance measures, better risk assessment, more streamlined credentialing, sharing of best practices, stronger quality controls, and other positive outcomes. The State should foster the development of affiliations among human services CBOs, informed by examples such as the independent practice association and Behavioral Health Care Collaborative models.

### ***5. ADDRESS CONTRACTUAL BARRIERS TO VBP PARTICIPATION***

In addition to inconsistent or duplicative regulations and policies, health and human services providers contend daily with inconsistent or duplicative contractual obligations and terms that discourage, rather than incentivize, better outcomes. Contract variation increases administrative burdens on all

parties because administering, complying with, and delivering on a variety of inconsistent agreements is labor-intensive and increases the risk of error. These burdens are exacerbated by the lack of uniformity in billing and reporting systems and the fact that most human services CBOs lack the resources necessary to assess risk and risk tolerance, negotiate fair terms, and develop sound contracts. Standardized contracts would offer clear pricing and terms of services and include language to minimize human services CBO risk. Replacing the fragmented contracting system with a more consistent and transparent approach would go a long way in helping all sectors collaborate in pursuit of the Triple Aim. Accordingly, we recommend that the State consider endorsing standardized contract language and pricing, looking to existing models such as the Ambulatory Patient Group methodology as examples.

#### **6. ENSURE THAT MEASURES OF SOCIAL DETERMINANTS OF HEALTH INTERVENTIONS ARE NOT OVERLY CLINICAL**

In order to address social determinants of health (SDH) in a meaningful, measurable way, all partners must have a clear understanding of how they affect health outcomes and what it takes for human services CBOs to deliver effective interventions. Furthermore, outcome measures must take into account the unique nature of social determinant interventions; they should not be overly clinical. Interventions aimed at addressing SDH often take more time than clinical interventions to yield results, and the results are not easy to capture. The Commission recommends that the State adopt a set of guiding principles for SDH measurement that reflect this reality.

#### **7. SHIFT RISK INCREMENTALLY AND COMMENSURATE WITH SERVICE LEVEL**

The full effect of SDH interventions will take time to manifest. As such, all stakeholders should allow for the transition to full-fledged value-based payment to happen over time, with risk-sharing evolving as the changes needed to transition to a more value-based system are made and outcomes become evident. The transition to VBP is a seismic shift, and most human services CBOs have low risk tolerance. Acknowledging and accommodating this reality, while making the investments set forth above, will allow human services CBOs to build stronger systems that enable them to withstand transitions in the funding environment. In the short-run, therefore, most human services CBOs must continue to be engaged in pay-for-reporting or upside risk-sharing arrangements with bonuses or cost savings.

This is an exciting moment in the evolution of New York's health care system. DSRIP has set us on the path towards realizing the State's vision and presents a remarkable opportunity to build a radically different health care system. With collaboration, strategic investment, targeted technical assistance, and regulatory reform, the State can translate this opportunity into a more cost-effective and sustainable system that delivers better care, better health, and lower cost for all New Yorkers.

## INTRODUCTION

New York State's current and long-term vitality depends on making sure that all of its residents have solid foundations for health and well-being throughout life so they can reach their full potential. New York's community-based human services organizations and the State's health care system are essential structures that our residents all rely on to stay healthy and engaged in our communities.

New York's health care system is in the midst of a massive and necessary reform aimed at shifting payment incentives to prioritize prevention, coordination, and integration to achieve the Triple Aim of:

- improving health outcomes;
- better quality of care; and
- and reducing costs.<sup>9</sup>

This reform is happening at an exciting time, when there is a growing appreciation for the connection between emotional, spiritual, and financial well-being and physical health. This recognition is driving an evolution in health care in which non-clinical interventions addressing housing, food security, mental health, substance use, social isolation, and more are increasingly being leveraged for improved health outcomes. These social, economic, and environmental conditions constitute 50 percent of the factors that influence an individual's health, far outweighing both clinical care (10 percent) and genetics (10 percent).<sup>10</sup> They are factors that community-based human services organizations (CBOs) are addressing daily as their central nonprofit missions. Incorporating social determinants of health (SDH) into the health care system is essential to achieving the State's reform goals.

The State is driving health care reform through a set of policy and payment changes accompanied by significant investments in the health care system designed to incentivize quality (as reflected in improved health outcomes or "value") over the number of services delivered (or "volume"). This approach to health care delivery is known as a "value-based payment" (VBP) model.

Improved outcomes and reduced cost will be very difficult to achieve without the vast network of human services CBOs, but the path for their engagement remains unclear. The episodic health care system must be intentionally linked with the interventions provided by these nonprofit organizations. Operational, infrastructure, and regulatory considerations are examples of key areas in need of reform for successful integration to happen.

The federal grants and policies that have paved the way for the VBP initiative in New York are all part of the Delivery System Reform Incentive Payment (DSRIP) program, which allows states to reward hospitals for meeting performance milestones. The New York State Department of Health formalized its DSRIP goals and objectives in 2015 with the issuance of the New York State Roadmap for Medicaid Payment Reform. The Roadmap makes explicit the expectation that human services CBOs will play a pivotal role in the future health care delivery system:

**"... the State envisions culturally competent community based organizations (CBOs) actively contracting with primary care organizations and health systems**

<sup>9</sup> "New York's Reinvestment Strategy: Achieving the Triple Aim." *Centers for Medicare & Medicaid Services*, [www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/Federal-State-Health-Reform-Partnership/ny-f-shrp-reinvest-strategy.pdf](http://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ny/Federal-State-Health-Reform-Partnership/ny-f-shrp-reinvest-strategy.pdf).

<sup>10</sup> Tarlov A.R. "Public policy frameworks for improving population health." *Annals of The New York Academy of Sciences.*; 896:281-93, 1999.

to take responsibility for achieving the State’s Prevention Agenda. DSRIP starts to build the infrastructure to take on housing, job placement, community inclusion, and criminal justice alternatives as levers to increase population health.”<sup>11</sup>

*The Blueprint for Partnership and Action* outlined in this report offers recommendations that will allow human services CBOs to become true partners that are “... actively contracting with ... health systems,” such that all parties—providers, payers, and those receiving services—reap the long-term benefits of a system that fosters collaboration and rewards coordination and prevention.

While the substance of our considerations and final recommendations were informed predominantly by a New York City perspective, the discussions and recommendations are applicable across the State.

This work builds off of a report issued by HSC in 2016, *New York Nonprofits in the Aftermath of FEES: A Call to Action*, which provided insight into the costs and risks of the human services sector’s participation in DSRIP soon after it was released. This in-depth analysis of the problems and opportunities human services CBOs faced as a sector following the closure of a number of nonprofit human services organizations noted the specific challenges of VBP and the restructuring of Medicaid. The report argued that though the State seemed to recognize human services CBOs’ effectiveness in delivering “the broad range of preventive interventions that will help New Yorkers become healthier,” it had not fully considered or addressed the financial costs and risks of Medicaid restructuring for the human services sector.<sup>12</sup>

This report was organized around these guiding beliefs:

- Bringing health and human services together to serve the “whole health needs”—physical health, mental health, and the social and economic factors—offers a unique opportunity for all sectors.
- Enabling human services CBOs to participate formally in health care delivery in regions and neighborhoods across New York puts a concrete value on the impact of their work.
- By fully examining the challenges facing our human services delivery system, we can better develop solutions focused on making human services CBOs more vital participants in the State’s full and successful transition to a more value-based care system.
- A collaborative solution must offer front-line health care providers and human services professionals the tools they need to achieve improved outcomes.

## The Work of the Commission

The impetus in forming the Commission on Value-based Care was the need to secure the human services sector a seat at the table—not as an add-on, but rather, as foundational to an integrated health care system that looks at health (both at the population level and the individual level) holistically to address the full range of factors impacting an individual. Because changes to the

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11 “A Path toward Value Based Payment: Annual Update.” *New York State Department of Health*, 2016, p. 41, [www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/2016/1st\\_annual\\_update\\_nystate\\_roadmap.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/2016/1st_annual_update_nystate_roadmap.htm).

12 *New York Nonprofits in the Aftermath of FEES: A Call to Action*. Human Services Council of New York, 2016. <http://humanservicescouncil.org/wp-content/uploads/Initiatives/HSCCommission/HSCCommissionReport.pdf>.

health system will affect the human services sector, we knew that inaction or inertia could result in policy and reform decisions that have unintended consequences for the human services sector, as well as in missed opportunities for creating a healthier New York.

The objective of the Commission was to identify the specific roadblocks and opportunities for human services CBOs to partner with health care, managed care organizations, and government to make this transition to value-based care successful. The resulting *Blueprint for Partnership and Action* captures the Commission's collective thinking on how to move forward.

The Commission focused on:

- Risks, challenges, and opportunities for human services CBOs in this rapidly evolving health and human services system and
- Changes needed to achieve greater collaboration and more robust partnerships among human services CBOs, health care providers and payers, and government.

A cross-section of leaders, including practitioners, philanthropic funders, health payers, consultants, and other experts in the human services and health delivery systems (spanning behavioral health and a wide range of community services) looked at ways to better connect health and human services to improve care and patient experience and reduce costs.

Through this work, we sought to identify models and contractual pathways for human services CBOs to contribute to improved health outcomes and utilize social determinants of health as a critical driver of outcomes. Four workgroups delved into the particular challenges including infrastructure support, approaches to measuring social determinants of health, regulatory and contractual hurdles, cross-sector partnerships, and assessing risk.

### **Factors Informing Commission Deliberations**

Among the factors considered were the very different universes in which the health care system and human services CBOs operate, with wholly different delivery and payment structures and a technology divide that prevents the collection of data necessary to assess individual and community needs and impact of services. For example, although Medicaid is a critical source of funding for both health and human services, there are substantial structural differences between health care providers and human services CBOs.

*Most health care providers are not able to address the effects of social and economic factors on their own, but they can leverage the expansive human services sector and make meaningful linkages to these expert providers through referral and reimbursement mechanisms that make good business sense for both sides.*

We know that most health care providers are not able to address the effects of social and economic factors on their own but can leverage the expansive human services sector and make meaningful linkages to these expert providers through referral and reimbursement mechanisms that make good business sense for both sides. At the same time, with no system-wide strategy for delivery and payment arrangements for their services, individual human services CBOs have been trying to find their way in this new health care world on their own. Many have remained on the sidelines, unsure of how to approach this new, complex, and risky terrain.

Barriers to participation are especially significant for smaller, non-Medicaid billing human services CBOs, even though they are often most embedded in the community, culturally competent, and well positioned to engage complex, diverse, at-risk populations. The State’s creation of a distinct category or “tier” for these non-Medicaid billing CBOs demonstrates a recognition of their value and potential contributions. In order to integrate with the health care system, however, these human services CBOs are likely to need somewhat specialized financial and contractual supports.

The current fragility of the sector must be addressed with urgency and long-term strategic thinking if human services CBOs are to be formally integrated with the health care sector in value-based payment arrangements. Value-based payment bears new risk structures requiring human services CBOs to present compelling value propositions and yield measurable outcomes in a short period of time. Human services CBOs have not received the support necessary to meet these requirements, and in fact, some are losing money on certain contracts. Government contracts routinely require private fundraising to cover the full cost of providing services, making the identification of additional resources for the purpose of value-based payment readiness nearly impossible.

Though the evidence calls for much greater collaboration between the health care delivery system and human services CBOs—and there are isolated examples of successful partnerships—much more targeted and robust financial and institutional support are needed to ensure large-scale change and sustainability.

To the extent that health care must take some responsibility for the costs of engaging human services CBOs in this work, hospitals and managed care organizations must be incentivized by government to think differently, share resources, and establish true partnerships that value the perspective, expertise, and contributions of human services CBOs in addressing social determinants of health.

## Background Information

The Commission engaged in discovery efforts to enhance our understanding of health care reform components, including DSRIP and Performing Provider Systems, social determinants of health, and the New York human services sector. Our research and findings are included at the end of this report as background materials and include:

- Health Care Reform and the Role of Human Services CBOs: CBO Classifications and Performing Provider Systems
- Profile of New York’s Human Services Sector
- Understanding—and Supporting—Human Services CBOs’ Role in Addressing Social Determinants of Health

In light of this information, we began to see the transition to VBP as an opportunity for a “reset” for health care payers and providers to engage the human services sector so that (1) care is efficiently coordinated; (2) risk is accurately calculated and fairly spread; and (3) contracts, rates, metrics, and payment structures are reasonable.

*The Blueprint for Partnership and Action* outlines the areas in need of attention if we are to move forward as a coordinated community of health and human services providers meeting the health and well-being needs of New Yorkers.



## A BLUEPRINT FOR PARTNERSHIP AND ACTION: RECOMMENDATIONS

To foster collaboration and partnership for long-term impact on health, the Commission is recommending actions that require financial and institutional buy-in by government and health care providers and payers, as well as cultural and structural changes in the human services sector.

Representatives of state and local government, health care (both providers and payers), and human services CBOs must together develop systemic solutions that go beyond the five-year DSRIP period to provide an enduring path for thriving human services CBO-health care partnerships. We are calling for a State-led process that involves negotiation between key stakeholders and includes elements of discovery, restructuring, and investment.

New York State has made some progress in transitioning the health care delivery system through DSRIP's reforms. The recent creation of the Bureau of Social Determinants of Health within the Department of Health and the dissemination of a survey to human services CBOs reflect the State's support for a fully integrated health and human services delivery system. But while human services CBOs have been involved to varying degrees, much more work must be done—and expeditiously—to produce outcomes that are appropriately recognized and reward human services CBOs in value-based payment arrangements.

To move forward with a planning process, there must first be recognition of the limitations of the current system, which creates redundancy, imposes extremely high administrative costs, and makes data sharing and care coordination inefficient. There must also be a clear understanding and recognition of the differences between how health care and human services operate. Key to this work will be the identification of incentives and approaches that align the respective goals of these two sectors.

We are recommending that all impacted sectors work together to develop clear steps for improving care experiences and health outcomes. This *Blueprint for Partnership and Action* can help guide a process to address the current obstacles through the development of concrete steps intended to move the marriage of health and human services ahead.

Laid out below are the specific recommendations for action. Some are well developed and actionable, while others are more conceptual and need further consideration. Addressing all of these recommendations will help drive systemic changes and enable human services CBOs to be viable participants in the evolving health care system.

## Recommendation 1: Bridge the technology divide

*Strengthening health care information management must begin with a full assessment of current systems used by all sectors and collaboration to streamline administrative processes and patient data information sharing through a “public good” system.*

Information technology plays a critical role in promoting collaboration and care coordination, facilitating outcome measurement and reporting, and streamlining payment. The success of VBP will largely depend on our ability to improve care and realize cost savings. Technology is a key element in achieving these goals efficiently and effectively. Unfortunately, the current landscape is a patchwork of many information systems, most lacking interoperability and working in isolation.<sup>13</sup> This leads to the very siloes that must be eliminated in order to achieve the Triple Aim of better care, better outcomes, and lower cost. Moreover, human services CBOs often lag behind in adoption of new systems due to resource constraints and government contract requirements obligating them to use single-purpose data systems.

Data collection, reporting, case management, billing, and payment systems that are currently in place must be examined with an eye toward understanding whether integration is possible. This process must include an assessment of the technology capabilities of human services CBOs compared to those of health payer systems to identify gaps and redundancies and establish standards and systems that will support the sharing of client data.

At the same time, an assessment of payer-mandated systems would reveal different payers using different systems, which creates heavy financial and administrative burdens for the human services CBOs that must set up and learn to use them. In particular, a full assessment of Regional Health Information Organizations (RHIOs) and Electronic Health Record (EHR) systems being used by many Performing Provider Systems (PPS) is imperative. Major investments have been made in these systems, and we must assess their strengths and flaws in order to make critical adjustments that promote inclusion of human services CBO partners.

The importance of SDH data cannot be overstated. The State—and health care providers and payers—must understand which SDH interventions are most likely to improve health outcomes, what it takes to deliver those interventions, and how to set outcome measures that make sense. We echo the recommendation of the Kaiser Family Foundation that state Medicaid agencies develop a framework for making strategic

### A Technological Hodgepodge

Having a comprehensive picture of what services people use is key to providing better, more person-centered care. In New York City, however, some human services CBOs are required to use multiple databases to report and track outcomes—in addition to the EHRs that they use for billing Medicaid for their outpatient clinic services. Most of these databases are not interoperable, and if a client uses multiple services at a single organization, it can be difficult to obtain a full picture of all services a person is receiving unless the organization maintains a separate database of their own. Settlement houses, which provide a wide range of services, are especially susceptible to these challenges. One, for example, reports using around 26 different databases—mostly government mandated—to track all of its data. This is not only inefficient but also creates an administrative burden.

<sup>13</sup> Some of these systems are not accessible to people with disabilities.



investments in the collection and use of SDH data.<sup>14</sup> We urge New York State to support human services CBOs in upgrading their capacity for data collection and reporting.

The State should also consider commissioning uniform systems to streamline administrative processes as a “public good” that could be customized through additional investment by each individual human services CBO.<sup>15</sup> A government-supported platform could not only facilitate collaboration across care settings but could also allow patients to engage more actively in their own care. This type of universal system would be especially helpful for smaller human services CBOs or niche players that want to participate in VBP arrangements. A State-supported “Human Services Technology Fund” would enable:

*The importance of data on social determinants of health cannot be overstated. The State—and health care providers and payers—must understand which SDH interventions are most likely to improve health outcomes, what it takes to deliver those interventions, and how to set outcome measures that make sense.*

- Health care-CBO partnerships that address SDH and result in savings;
- Greater coordination among human services CBOs that specialize in different interventions (e.g., food, housing, education, job training, criminal justice, etc.);
- Improved services that are informed by a 360-degree view of patient interventions and outcomes, made possible by interoperable health care and human services CBO technology;
- Better data collection and analysis of SDHs;
- More accessible government and nonprofit social services; and
- Improved life outcomes for children, adults, and families.

## **Recommendation 2: Undertake a comprehensive review and overhaul of regulatory requirements**

*Only with comprehensive and strategic regulatory relief and greater standardization can the Triple Aim be achieved.*

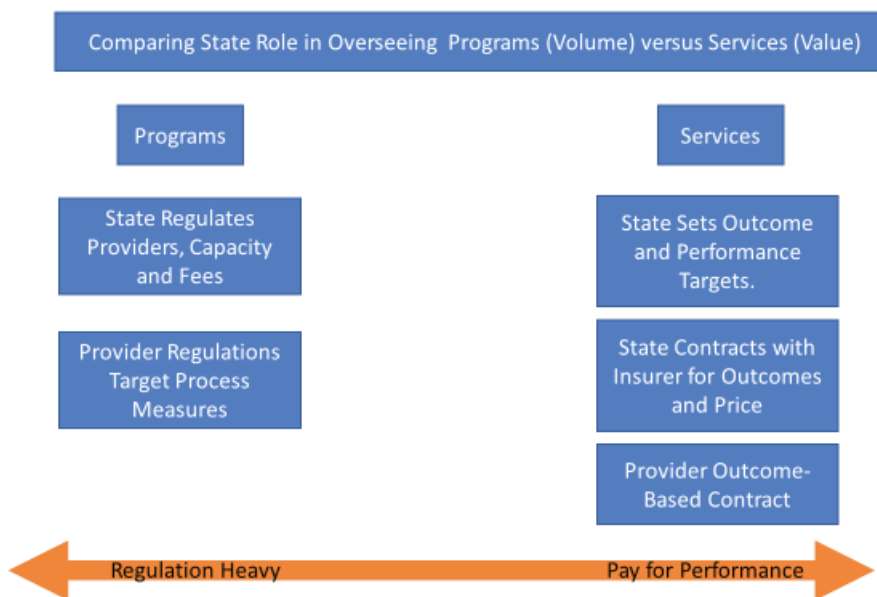
While the State has moved towards a population health focus that prioritizes outcomes, the legal framework that governs health care and human services has remained largely unchanged, hindering innovation and creating inefficiencies. State and local agency regulations are particularly problematic because there are barriers to coordination among rulemaking bodies and to replacing prescriptive regulations with outcome-based requirements. There is also a redundancy between oversight provided by managed care organizations (MCOs) and New York State regulations. Inconsistent, contrary, and duplicative regulations increase administrative costs, restrict creativity, and discourage collaboration.

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14 Heiman, Harry J., and Artiga, Samantha. “Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity.” Nov. 4, 2015, *The Henry J. Kaiser Family Foundation*, [www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/](http://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/).

15 Uniform systems should meet the Web Content Accessibility Guidelines 2.1. See Caldwell, Ben, et al. “Web Content Accessibility Guidelines (WCAG) 2.1.” *The World Wide Web Consortium*, Jan. 2018, [www.w3.org/TR/2018/CR-WCAG21-20180130/](http://www.w3.org/TR/2018/CR-WCAG21-20180130/).

The graphic below shows the spectrum of State oversight vis-à-vis volume-based arrangements and value-based arrangements.



We must engage in a thorough review process in which existing legislation, regulations, and policies are analyzed to identify those that could be streamlined, amended, or eliminated in order to remove barriers to partnering with health care. This process should also identify opportunities to standardize reporting among all payers (by commissioning a universal platform), unify credentialing, and incentivize coordination of care. All State agencies contracting with human services CBOs, including the Department of Health, the Office of Mental Health, the Office of Children and Family Services, the Office of Temporary and Disability Assistance, the Office of Alcoholism and Substance Abuse Services, the Office for People with Developmental Disabilities, and the Office of Medicaid Inspector General, must be involved in the process to ensure that the full picture of regulations human services CBOs are expected to comply with is captured and addressed. Local government agencies must also be involved.

Following this, we must develop a framework that promotes outcomes-based accountability while allowing flexibility to innovate. This will require a transition plan that shifts the culture of oversight to a flexible model that entrusts human services CBOs with the responsibility to deliver on agreed upon outcomes.

A collaborative rulemaking process should also be explored to ensure that future regulatory changes are not made in isolation.<sup>16</sup> Review cannot be a one-time undertaking. Rather, it must be an iterative, ongoing process that keeps pace with changing needs.

**Credentialing Challenges**

One OMH-licensed clinic provider recently had a clinical administrator spend three hours a day for a week working to credential clinical staff with various Medicaid Managed Care plans. There is significant additional cost in producing unique clinical credentialing packets for multiple plans. Standardizing credentialing across plans would help reduce this burden.

<sup>16</sup> This may require legal research to determine the extent to which agencies are authorized to collaborate.

### **Recommendation 3: Make investments and build systems that support stronger and more informed relationships between health and human services CBOs**

*New York State is clearly persuaded by the significant body of research on social determinants of health and is leading the nation in incorporating these interventions into its health care delivery system. For the collaboration between health and human services to succeed, formal systems for supporting partnerships between human services CBOs and health payers must be established.*

In some ways, health and human services are strangers living next door, working in close proximity but unaware of the details of each other's lives. To work together towards the State's goals, they must have some knowledge of each other's drivers, challenges, strengths, and limitations.

For this reason, it is important that learning and networking opportunities to bring the two sectors together are fostered. The database that the Department of Health is creating based on its human services CBO survey is a good step towards encouraging cross-sector networking.

The health care system should also be educated on how to craft requests for proposals (RFPs) for human services CBO partnerships. Currently, these documents are too prescriptive. More open RFPs in which health payers identify broad goals and human services CBOs are required to put forward an appropriate scope of service are an example of an approach that should be explored. A list of key principles or elements of an ideal RFP, such as funding of all costs, a reasonable definition of indirect costs, adequate time to respond, and an opportunity to negotiate post-award, can also be developed.

Networking events that allow human services CBOs to "pitch" their value propositions to health care providers and payers in real time could also be fostered, but it is imperative that we recognize and address the imbalance of power and resources between human services CBOs and payers. The vast majority of human services CBOs are under-resourced and lack experience partnering with the health care system. Accordingly, they will need an infusion of resources to develop the systems necessary to effectively engage with complex and sophisticated health care institutions.

A State commitment to increasing support for human services CBO infrastructure, either by investing directly or by incentivizing health payer investments in human services CBO infrastructure, is also critical. An example of a comprehensive, statewide investment that is strengthening the sector is the Nonprofit Infrastructure Capital Investment Program (NICIP).

The State should consider establishing a program like the NICIP for human services CBOs seeking to

#### **Addressing Human Services Infrastructure Needs**

The Nonprofit Infrastructure Capital Investment Program (NICIP) was established by legislation in 2015 to address the urgent need to strengthen the State's nonprofit human services infrastructure. Over three years, the State appropriated \$120 million for competitive NICIP awards that human services CBOs could use to repair, expand, or renovate their existing facilities. A portion of the funding was set aside for technology upgrades. The demand for these dollars is overwhelming: 635 organizations applied for more than \$300 million in funding. Despite some administrative setbacks, the program is on track to support more than 200 nonprofit capital improvement projects across the State.

participate in value-based payment arrangements. The program could cover training and technical assistance, technology upgrades, or consulting services. The State could also encourage support by health care providers and payers through medical loss ratio savings.<sup>17</sup>

Another precedent for supporting infrastructure costs of human services CBOs in the contracting process can be found in the practice of the State Office of Mental Health, which routinely offers

*Health and human services are like strangers living next door, working in close proximity but unaware of the details of each other's lives.*

funding for program development grants equivalent to six months of an awardee's operating budget to acquire supplies and equipment, and hire and train staff. These kinds of arrangements could be included in VBP contracts and extend for three to five years to allow sufficient time to get off the ground and focus on outcomes rather than process.

Finally, while the State should continue to facilitate health care provider learning through targeted programs like VBP University and the VBP Bootcamps, it would be helpful for managed care organizations (MCOs) to have an SDH expert on staff to develop strategies for assessing community needs, identifying target SDHs, coordinating with other MCOs, and engaging with human services CBOs to select and implement effective interventions. This expert would represent a true link between health and human services, advocating for seamless delivery of "whole health" care.

#### **Recommendation 4: Provide greater and more targeted support for establishing provider networks**

*Collaboration among human services CBOs is more conducive to person-centered, whole health care. It allows for better coordination with health care partners to offer interrelated services as a continuum of care.*

Human services CBOs must work together in formal and informal ways to engage with health care payers. Affiliations can increase an individual organization's capacity for relationship management and contract negotiations, leading to fairer pricing and revenue sharing approaches, more appropriate performance measures, better risk assessment, more streamlined credentialing, sharing of best practices, stronger quality controls, and other positive outcomes.

The independent practice association (IPA), which is used widely by physicians, is an example of an effective affiliation model. An IPA is a state-regulated, special purpose legal entity that can be used to facilitate joint negotiation with MCOs and other payers. With roots in physician practice groups, IPAs are a legal mechanism that requires integration of standards and services among health service providers, and allows for joint negotiation on behalf of its members while complying with regulatory restrictions.<sup>18</sup> The IPA is a legal construct that enables cost sharing and reduces administrative burdens while increasing bargaining power.

Another affiliation model is the State-funded Behavioral Health Care Collaborative (BHCC). BHCCs

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<sup>17</sup> Medical Loss Ratio (MLR) is the proportion of premium revenues spent on clinical services and quality improvement. The Affordable Care Act sets minimum medical loss ratios for different markets, as do some state laws.

<sup>18</sup> "Managed Care Organizations," 10 *New York Codes, Rules and Regulations* § 98-1.2(w) (2009).

are networks of a broad range of behavioral health, physical health, substance abuse, and other child, adult, and family human services.<sup>19</sup> Governor Cuomo recently awarded nineteen BHCCs a total of \$60 million “to integrate care across the entire spectrum of physical and behavioral health services.”<sup>20</sup> These types of investments enable establishment of the formal networks needed to connect independent human services CBOs with health care providers and payers. We should build on the progress that has been made in the behavioral health arena and continue to expand and diversify these affiliations with a broader set of human services CBOs.

## Recommendation 5: Address contractual barriers to VBP participation

*Replacing the fragmented contracting system with a more transparent and consistent approach would go a long way in helping all sectors.*

In many respects, the State is building a value-based health care system on a volume-based foundation. Remnants of the old foundation include existing laws and regulations and a fee-for-service contractual model that presents numerous challenges. For example, reconciliation of fee-for-service or contracted services occurs long after a program has been delivered, is administratively costly, and uses a program-specific lens. Some contracts even penalize human services CBOs that perform well and spend judiciously by reducing their payment to equal their actual expenditures rather than the value of their services. This incentivizes the spending down of the contract and eliminates the possibility of high-performing human services CBOs creating operating and/or capital reserves, which in turn perpetuates financial instability.

There is also great variation among existing VBP-related contracts. At its inception, the State’s Medicaid Redesign Team (MRT) envisioned a handful of plans that would cover specialized behavioral health services. Today, there are eleven Medicaid Managed Care plans and twelve Health Homes in New York City alone with little or no standardization. Contract variation increases administrative burdens on all parties because administering, complying with, and delivering on a variety of inconsistent agreements is time-consuming and increases the risk of error. This is further complicated by the lack of uniformity in billing and reporting systems and the fact that most human services CBOs lack the resources necessary to assess risk and risk tolerance, negotiate fair terms, and develop sound contracts.

### Efficient Contracting Approaches

The Health Home program is an excellent example of a model of a shared performance contract structure. In this model, a centralized Health Home would be the at-risk entity billing for a network of agencies and distributing funds where agencies report key data and have quality accountability responsibilities. This could be replicated by housing services, for example, which could provide home and community-based waiver services under the umbrella of a lead organization with the Home and Community-based Services (HCBS) designation.

We recommend considering standardized contracts that could weave together all SDH services

<sup>19</sup> It is important to note that currently, the only way to avoid antitrust violations when negotiating with payers is through an IPA. In this regard, BHCCs are not an alternative to IPAs.

<sup>20</sup> “Governor Cuomo Announces \$60 Million in Awards to Mental Health and Addiction Healthcare Providers to Lower Cost and Improve Outcomes.” *Governor Andrew M. Cuomo*, New York State, 4 Jan. 2018, [www.governor.ny.gov/news/governor-cuomo-announces-60-million-awards-mental-health-and-addiction-healthcare-providers](http://www.governor.ny.gov/news/governor-cuomo-announces-60-million-awards-mental-health-and-addiction-healthcare-providers).



for a payer with clear pricing and terms for services that are usually paid for on a contract or fee-for-service basis. Parties could adopt tested contract language for their VBP arrangements. Such language must minimize the risk to human services CBOs and should reward them for good performance. Cost escalation clauses and definitions of indirect costs are examples of the types of terms that can be established through this process. Providing standardized language while leaving room to negotiate price on an individual basis would greatly reduce administrative burdens in the short-run by simplifying the contracting process and, in the long-run, by fairly allocating risk and making contracts easier to comply with.

The State should also consider standardizing billing for human services CBOs. An example of this type of administrative simplification is the Ambulatory Patient Group (APG) billing process developed by the New York State Office of Alcoholism and Substance Abuse Services (OASAS). Implemented in 2011 as part of the State's overall health care reform effort, the APG billing process was designed to make Medicaid reimbursement more rational.<sup>21</sup> It has two key components: (1) a catalog of ambulatory care procedures and (2) weighted reimbursement rates set by the State. Unlike the old ambulatory care reimbursement system, which was inconsistent and did not accurately reflect the cost of vastly different services, this new methodology provides predictability, facilitates clinical targeting, and generally results in greater reimbursement for high-intensity services and lower reimbursement for low-intensity services.<sup>22</sup>

### The Contractual Maze

In New York City, each performing provider system has unique performance measures and contracts. A human services CBO that participates in three PPSs must negotiate three separate contracts with three unique tracking and reporting structures and must attend a significant number of meetings. While these processes are burdensome for the health care provider, they are even more so for the CBO because of the limitations on CBO capacity. This burden is excessive and drains already taxed resources.

In the case of Medicaid Managed Care Plans for the Adult Home and Community Services Waiver, the process did not include a model contract format, causing multiple providers to bear the expense of creating virtually identical documents.

21 "General APG Background" *Ambulatory Patient Groups*, New York State Office of Alcoholism and Substance Abuse Services [www.oasas.ny.gov/admin/hcf/apg/index.cfm#GeneralAPGBackground](http://www.oasas.ny.gov/admin/hcf/apg/index.cfm#GeneralAPGBackground). "As part of the transition to Medicaid Managed Care, the APG Rates will be mandated until March 2020. During the transition, providers in some instances will continue to bill on a fee for service basis with the APG Methodology." *Ambulatory Patient Groups (APG) Policy and Medicaid Billing Guidance*. New York State Office of Alcoholism and Substance Abuse Services, Feb. 2018, [www.oasas.ny.gov/admin/hcf/apg/index.cfm#GeneralAPGBackground](http://www.oasas.ny.gov/admin/hcf/apg/index.cfm#GeneralAPGBackground)

22 OASAS explains:

The outdated methodologies were often based on fixed dollar payments that did not vary by severity of illness or complexity of procedure. These antiquated reimbursement methodologies thwart the appropriate migration of services from costly acute care settings to less costly primary and preventive care settings.

"General APG Background" *Ambulatory Patient Groups*, New York State Office of Alcoholism and Substance Abuse Services [www.oasas.ny.gov/admin/hcf/apg/index.cfm#GeneralAPGBackground](http://www.oasas.ny.gov/admin/hcf/apg/index.cfm#GeneralAPGBackground).

A sample APG rate schedule follows.<sup>23</sup>

APG Rate Codes: Outpatient Clinic/Rehab					
		As of January 2018		As of April 2018	
Type of Program	Rate Code	Base Rate Upstate	Base Rate Downstate	Base Rate Upstate	Base Rate Downstate
Freestanding SUD OP Clinic	1540	\$148.83	\$173.67	\$150.36	\$175.93
Freestanding SUD OP Rehab	1573	\$148.53	\$173.80	\$150.52	\$176.12
Hospital Based SUD Op Clinic	1528	\$147.41	\$184.58	\$149.32	\$186.98
Hospital Based SUD Op Rehab	1561	\$141.42	\$184.70	\$143.31	\$187.18

In addition to standard contract language or reimbursement rates, a set of contracting principles should be developed to guide VBP partnerships. These principles should emphasize meaningful negotiation, reasonable allocation of risk, focus on outcomes, economic fairness (including coverage of all legitimate costs and allowance for cost escalation over time), and of course, person-centeredness. If parties develop provisions beyond the standard terms, those provisions should be guided by these principles. In addition, the State should establish an arbitration process to ensure that these principles are adhered to.

## **Recommendation 6: Ensure that measures of social determinants of health interventions make sense and are relevant to population health goals**

*Measures must reflect the unique nature of SDH interventions and the reality of the work being done, rather than being clinically focused.*

To ensure effective human services CBO participation in pursuit of the Triple Aim, appropriate measures for SDH services must be put in place. SDH interventions often take more time than clinical interventions to yield results, and the results are not easy to capture.<sup>24</sup> Measures must reflect this reality.

<sup>23</sup> *Ambulatory Patient Groups (APG) Policy and Medicaid Billing Guidance*. New York State Office of Alcoholism and Substance Abuse Services, Feb. 2018, [www.oasas.ny.gov/admin/hcf/APG/documents/APGManual.pdf](http://www.oasas.ny.gov/admin/hcf/APG/documents/APGManual.pdf).

<sup>24</sup> The measures selected by the MRT's Clinical Advisory Groups (CAGs), for example, are not aligned with the more qualitative nature of SDH.

The Commission articulated a set of guiding principles for SDH impact measurement. Measures must be:

- Practical
- Reportable
- Actionable
- Incremental
- Neutral with respect to the size of the organization
- Person-centered
- Based on existing data and data systems
- Aligned with funding

Measures should also address patient engagement, a key to achieving better outcomes. Engagement includes hospitals working closely with the human services CBOs that they partner with so that the human services CBOs know how to engage the patients in their care and vice versa. Release from the hospital and the handoff to human services CBOs must be seamless, efficient, effective, timely, transparent, and compassionate.

Furthermore, given the longer timeline of SDH interventions, measures should evolve. They might be process-oriented in the beginning, with providers being paid for the intervention, and transition over time to outcome measures as quantifiable success is demonstrated and it becomes clear what is realistic.

## **Recommendation 7: Shift risk incrementally and commensurate with service level**

*All stakeholders must allow for the transition to true VBP to happen over time, with risk-sharing evolving while the changes needed to transition to a more value-based care system continue to be made.*

In the short-run, most human services CBOs will continue to be engaged in pay-for-reporting or upside risk-sharing arrangements with bonuses or cost savings, as they are not currently positioned to take on additional risk and the transition to VBP is a seismic shift. Acknowledging and accommodating this reality, while making the investments set forth above, will allow human services CBOs to build more robust systems that enable them to withstand transitions in the funding environment. The State should actively support the accumulation of reserves across all human services CBO contracts during this transitional phase. Of course, each human services CBO will have to assess its own readiness for VBP, and the State should continue its work to actively support these efforts.<sup>25</sup>

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<sup>25</sup> The Nonprofit Finance Fund has released a pair of tools to help human services CBOs assess their readiness for partnerships with health care providers and to evaluate the effectiveness of their existing partnerships:

- For CBOs *considering* partnering with healthcare organizations: the *Nonprofit Readiness for Health Partnership* tool helps “identify capacity or investment needs so they can be well positioned to explore partnership opportunities.” “Nonprofit Readiness for Health Partnership.” *Nonprofit Finance Fund*, <https://nff.org/fundamental/nonprofit-readiness-health-partnership>
- For CBOs and healthcare organizations *already engaged* in partnerships, the *Partnership Assessment Tool for Health (PATH)* “provides a format to understand progress toward benchmarks characteristic of effective partnerships, identify areas for further development, and guide strategic conversation.” “Partnership Assessment Tool for Health.” *Nonprofit Finance Fund*, <https://nff.org/fundamental/partnership-assessment-tool-health>.



The full effect of SDH interventions will take time to manifest, and risk sharing should evolve at the same rate. The risk borne by human services CBOs should be commensurate with the system’s progress on the human services CBO *Blueprint*.

As demonstrated by the table below,<sup>26</sup> which appears in the VBP Roadmap, the State has recognized the need to ease into VBP arrangements.

New York State VBP Risk Level Definitions	
Acronym	Description
VBP Level 0	This initial level of VBP consists of fee-for-service (FFS) with bonus payments and/or bonus withholding based on quality scores. There is no risk sharing in this arrangement.
VBP Level 1	This level consists of FFS with upside-only shared <i>savings</i> when outcome scores are sufficient.
VBP Level 2	This level consists of FFS with <i>risk</i> sharing (upside available when outcome scores are sufficient; downside is reduced when outcomes scores are high)
VBP Level 3	This type of arrangement is feasible only after experience. As such, it requires a mature performing provider system (PPS). This level consists of global capitation (with an outcome-based component).

<sup>26</sup> *A Path toward Value Based Payment: Annual Update*. New York State Department of Health, March 2016, [www.health.ny.gov/health\\_care/medicaid/redesign/dsrip/docs/1st\\_annual\\_update\\_nystate\\_roadmap.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/dsrip/docs/1st_annual_update_nystate_roadmap.pdf).

## CONCLUSION

Health care reform is at a critical moment in New York, and the State is leading the nation in the integration of health and human services. A successful transformation requires a change in perspective by all sectors, as well as systemic investment to build capacity among all stakeholders. DSRIP is a strong foundation for a sustainable new system, but the incentives for change cannot end when DSRIP ends. All sectors—government, health care, human services, and even philanthropy—must continue to work together to move the system toward greater integration. Only then will we achieve and maintain positive, equitable, and sustainable health outcomes for communities. *The Blueprint* is a guide for this important work.

The work of this Commission is intended to move the process forward in a way that brings all parties together to construct viable solutions for improving health outcomes and patient experience while reducing costs. We agree with the State's progression to value-based care. It is right-minded and a noble aspiration to improve the health care outcomes of people enrolled in Medicaid and could be applied to larger health care concerns.

To move beyond aspiration into action, all parties together must develop the details of our collective path forward. Human services CBOs are ready to work to implement *The Blueprint* and optimistically embrace the challenge of building a viable continuum of health and human services.

There is much work to do, and we look forward to joining together to advance this *Blueprint for Partnership and Action*.

## ACKNOWLEDGEMENTS

HSC commends the New York State Department of Health for leading the nation in integrating health and human services. By recognizing the significant influence of social factors on health outcomes and creating real incentives for health and human services providers to address them in partnership, the State is taking a bold step towards achieving better outcomes for all New Yorkers.

This report would not have been possible without the thoughtful, candid contributions of the Commission members. These leaders with expertise in human services, health care, government, and philanthropy devoted a substantial amount of time over the course of a year to exploring difficult—and at times existential—questions in a meaningful way. We thank them for their collaborative approach and unwavering commitment to our common goal. A list of the Commission members appears in the appendices to this report.

We are especially grateful for the leadership of the Commission Chair, Dr. Lilliam Barrios-Paoli, who brought cross-sector knowledge from her rich and extensive career, including her role as New York City Deputy Mayor for Health and Human Services. We are also grateful to the Commission members who chaired the four working groups, through which much of our work was carried out: Dr. Jorge Petit of Coordinated Behavioral Care; Pamela Mattel of Acacia Network; Arthur Webb of Arthur Webb Group; and Bruce Feig of Sachs Policy Group. We also thank Jason Helgerson, former New York State Medicaid Director, Dr. Ram Raju of Northwell Health (formerly of NYC Health + Hospitals), and Dr. Oxiris Barbot of the New York City Department of Health and Mental Hygiene, each of whom attended and presented at a Commission meeting. They provided thought-provoking insights that led to rich discussions and helped advance our work.

Kristin Woodlock, our content advisor, served as our guide through the complex terrain of health care reform, providing expertise on the mechanics of health care delivery and payment reform as well as on key stakeholders and relationships.

Mindy Liss put together the initial draft of the report, distilling a year's worth of conversations, research, and email exchanges into one document. She attended every Commission meeting and captured the essence of the Commission's ideas. Jina Paik of the Nonprofit Finance Fund provided important insight regarding the financial and operational implications of value-based payment for nonprofit human services CBOs.

Jennifer Burner Barden of Risa Heller Communications was the public relations consultant for this project, offering invaluable insights on communicating our message effectively. Bridget Gavaghan of the National Human Services Assembly provided invaluable feedback on the overall tone and messaging of the report.

The HSC staff and interns were instrumental in producing this report. Tracie Robinson, Senior Policy Analyst, coordinated the work of the four Commission work groups, facilitating meetings, participating in discussions, drafting correspondence, guiding the work of our interns, synthesizing key ideas and points of consensus, and ensuring mission alignment across work groups. She also made significant contributions to the writing process, coordinating the research, drafting several sections, and revising and proofreading multiple versions of the report, including the final draft.

Luis Saavedra, Executive Assistant, deftly managed every logistical detail of the Commission's work. His diligence and attention to detail kept the Commission members seamlessly engaged

throughout the year. Iona Tan, Communications Associate, developed the report design and layout, and Jason Wu, Membership Services Manager, managed the report printing and release. The entire staff assisted in proofreading the report. Our intern Gillian Su contributed extensive research on social determinant interventions and measures to our work. She also worked with Mret Khine, our Public Service Scholar, to ensure that all sources were properly cited.

The foresight and leadership of HSC's Executive Director, Allison Sesso, were the impetus for this report. Allison took the initiative in convening a group of thought leaders and practitioners to examine the role of human services in the new health care delivery and payment system. She was deliberate in identifying Commission members, consultants, guest speakers, and partners, seeking diversity of experience and perspective. Allison set the vision for the Commission's work, and brought the voice of the human services sector to the center of every conversation.

HSC acknowledges the generous support of the Altman Foundation, whose funding made this report possible. Since 1913, the Foundation has been a steadfast supporter of organizations and programs that enrich the quality of life and enable individuals, families, and communities to achieve their full potential. The Foundation makes grants in the areas of health, education, community development, cultural engagement, and services to nonprofit organizations. We thank the Altman Foundation for enabling us to carry out the important work of shaping health care reform.

We also acknowledge The Clark Foundation, The New York Community Trust, and The Kresge Foundation for making significant investments in the work of the Human Services Council and, of course, HSC's 170 members, whose collective investment makes the very existence of HSC possible.

Participation in the Commission and/or support by these funders does not constitute implicit or express endorsement of the contents of this report.

Finally, we thank the HSC Board of Directors whose sound stewardship of the organization have enabled HSC to be a strong representative of the human services sector in New York. A list of our Board members can be found in the appendices to this report.

This report, although a significant undertaking, is just the beginning of our journey towards a value-based system of health care. We are deeply grateful to all who made it possible, and we are excited to continue our collaboration for the long-term success of health care reform.

## **BACKGROUND INFORMATION**

***I. HEALTH CARE REFORM AND THE ROLE OF HUMAN SERVICES CBOS: CBO CLASSIFICATIONS AND PERFORMING PROVIDER SYSTEMS***

***II. PROFILE OF NEW YORK'S HUMAN SERVICES SECTOR***

***III. UNDERSTANDING—AND SUPPORTING—HUMAN SERVICES CBOS' ROLE IN SOCIAL DETERMINANTS OF HEALTH***

## I. HEALTH CARE REFORM AND THE ROLE OF HUMAN SERVICES CBOS: CBO CLASSIFICATIONS AND PERFORMING PROVIDER SYSTEMS

The five-year VBP Roadmap issued in 2015 represented New York State’s vision for reforming its health care payment and delivery models, as required by the Federal waiver under Section 1115 of the Social Security Act. The State’s health care reform plan is known as the Delivery System Reform Incentive Payment (DSRIP) program. State policymakers saw the VBP Roadmap as a long-term model beyond the DSRIP waiver period, believing that DSRIP could *begin* the process of shifting the State to a VBP approach to health care payments. The State’s investment in DSRIP was substantial, but it included relatively little funding specifically for the integration of human services CBOs into the system of care.

New York State started its reform plan with a series of recommendations to lower spending immediately and implement future reforms. The State set a goal to work towards 80 percent value-based payments for managed care covered lives by the end of the waiver period (in 2020). New York is currently more than half-way through this redesign process.

Though there is enormous diversity in size and scope among human services CBOs supported by Medicaid and other public and private funding, the VBP Roadmap set out a fairly rigid categorization of CBOs into three tiers referencing CBO Tier 1, 2, or 3. The table below describes each tier.<sup>27</sup>

New York’s DSRIP CBOs	
Tier 1	Nonprofit, non-Medicaid billing, community based social and human service organizations ( <i>e.g.</i> , housing, social services, religious organizations, food banks)
Tier 2	Nonprofit, Medicaid billing, non-clinical service providers ( <i>e.g.</i> , transportation, care coordination)
Tier 3	Nonprofit, Medicaid billing, clinical, and clinical support service providers (licensed by the NYS Department of Health, NYS Office of Mental Health, NYS Office for Persons with Developmental Disabilities, or NYS Office of Alcoholism and Substance Abuse Services)

<sup>27</sup> *A Path toward Value Based Payment: Annual Update*. New York State Department of Health, March 2016, [www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/docs/1st\\_annual\\_update\\_nystate\\_roadmap.pdf](http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/docs/1st_annual_update_nystate_roadmap.pdf).

At the outset of its plan, as a condition of receiving DSRIP funding, New York required Medicaid-billing health care providers and human services CBOs to form integrated delivery networks, referred to as Performing Provider Systems (PPSs) but engagement, participation, and funding of human services CBOs as partners in PPS networks has been limited.

In the absence of a comprehensive and fully funded system-wide strategy for delivery and payment of their services, most CBOs have been navigating this new landscape on their own. Partnerships have been piecemeal and often the result of individual organizations pushing for what they need to move forward. The redesign mandated a payment relationship between Medicaid-funded CBOs (Tiers 2 and 3) and managed care organizations (MCOs) for behavioral health services, which opened the door for conversations around the purchase of non-Medicaid services addressing social determinants, but few actual agreements for the provision of these services have been created.

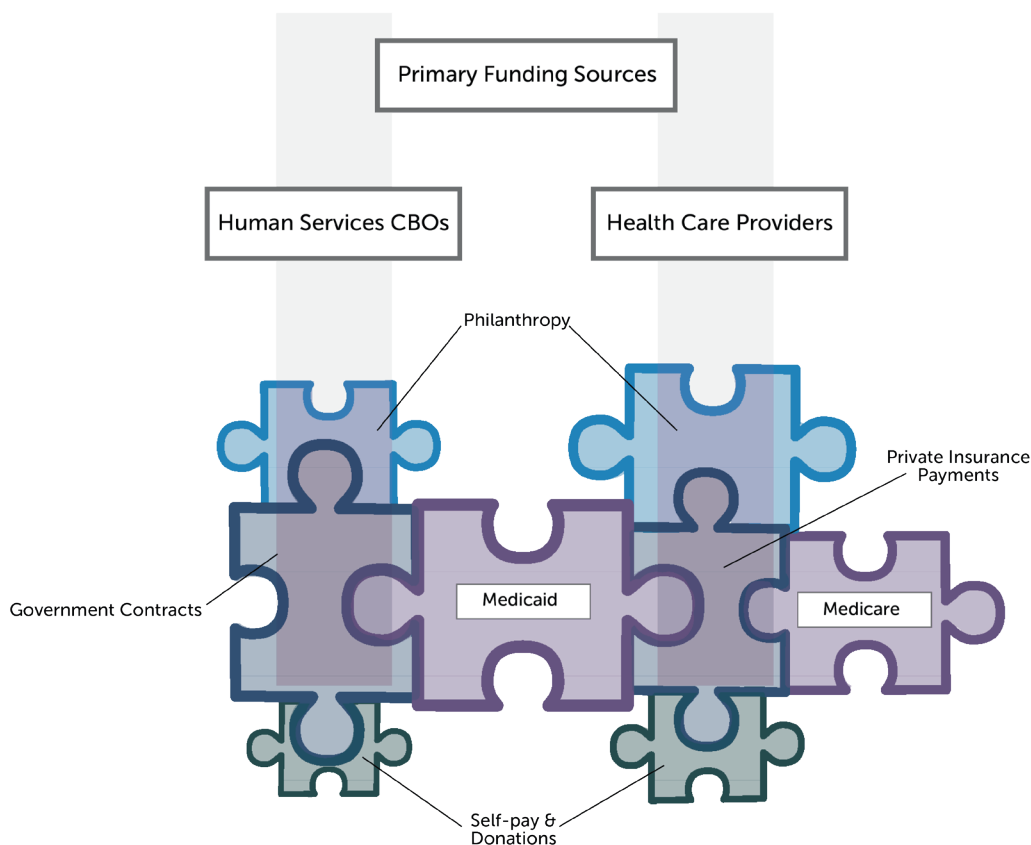
To encourage the engagement of non-Medicaid billing (Tier 1) human services CBOs, the State has required each PPS to contract with at least one of these organizations. This has proven challenging as there is no clear incentive for non-Medicaid funded CBOs to engage with health care payers and no natural way to create relationships between these human services CBOs and the health care system.

It is worth noting that Medicaid is a common funding source of the health and human services CBO sectors, but important structural differences between their other primary funding sources lead to significant operational and cultural differences. Deficit-funded government contracts and divergent accountability mechanisms and performance incentives are key drivers of these differences.

### The Behavioral Health Transition

The redesign of New York State's Medicaid program included the transition of behavioral health services into Medicaid Managed Care. Prior to implementation, advocates secured protections for human services CBOs providing Medicaid funded behavioral health services including broad network inclusion parameters and a requirement that Medicaid Managed Care Plans continue to pay providers at rates set by the State through 2020.

While the rates were mandated, human services CBOs providing Medicaid funded behavioral health services (CBO Tier 3) were required to bill and communicate with multiple Managed Care plans, each with their own contracting, credentialing, and service authorization processes. This brought great expense and complexity to the payment process and created variability and lags in payment that have resulted in serious cash-flow challenges for these human services CBO providers.



The graphic depicts the primary pieces of the funding puzzle supporting health and human services, with Medicaid placed in the middle connecting both systems.<sup>28</sup>

## II. PROFILE OF NEW YORK'S HUMAN SERVICES SECTOR

Though lines between health care and social and behavioral health services have been blurring, there remains a significant gap in understanding precisely how social determinants of health affect the delivery and costs of health care in our country. In the recent report, *Social determinants of health: How are hospitals and health systems investing in and addressing social needs?*, Deloitte contends that while there has been some increased investment in health-related social needs, “much activity is still ad hoc ... and gaps remain in connecting initiatives that improve health outcomes or reduce costs.”<sup>29</sup> A clearer understanding of the human services sector—both its long and important history and its current state of affairs—is needed in order for all sectors to move forward in a meaningful way.

The substantial growth in New York’s nonprofit human services sector has come in response to a host of social, demographic, and economic changes. The State and its local governments have turned to nonprofit organizations to provide critical services. These are public services that benefit many populations, including children and those with low incomes striving to enter the middle class. Millions of New Yorkers are directly served, and all New Yorkers reap the benefits of more

<sup>28</sup> The puzzle pieces are not to scale.

<sup>29</sup> *Social determinants of health: How are hospitals and health systems investing in and addressing social needs?* Deloitte, 2017, [www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-addressing-social-determinants-of-health.pdf](http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lshc-addressing-social-determinants-of-health.pdf).



stable communities when their neighbors are able to pursue healthy and satisfying lives and seek better opportunities.<sup>30</sup> To best leverage all that human services CBOs have to offer, the episodic health care system must be intentionally linked with the interventions provided by these nonprofit organizations.

The human services sector is a significant segment of the State's economy, delivering billions of dollars in services on behalf of the State and local governments and employing roughly 332,000 people,<sup>31</sup> a number that has doubled since 1990. In New York City, the number of people employed by human services organizations has increased by 82 percent.<sup>32</sup> Human services organizations operate programs that help New Yorkers of all backgrounds, means, and abilities reach their full potential. Their programs include elder care, child care, a wide range of child and adult education programs, employment services, youth development programs, services for people involved in the justice system, disaster relief, mental health services, substance abuse prevention and treatment programs, supports for people with disabilities, housing and food assistance, legal services, and many others. All of these interventions impact key social determinants of health.

The mission statements below demonstrate the role that human services CBOs play in addressing social determinants of health.

**Community Access:** Community Access expands opportunities for people living with mental health concerns to recover from trauma and discrimination through affordable housing, training, advocacy and healing-focused services.

**Project Renewal:** Project Renewal's mission is to end the cycle of homelessness by empowering adults and children to renew their lives with health, homes, and jobs.

**Partnership with Children:** Partnership with Children works to strengthen the emotional, social, and cognitive skills of vulnerable children in New York City to help them succeed in school, society, and life.

**VISIONS / Services for the Blind and Visually Impaired:** VISIONS' mission is to develop and implement programs to (1) assist people of all ages who are blind or visually impaired to lead independent and active lives in their homes and communities and (2) educate the public to understand the capabilities and needs of people who are blind or visually impaired so that they may be integrated into all aspects of community life.

30 *Undervalued and Underpaid: How New York State Shortchanges Nonprofit Human Services Providers and their Workers*. Restore Opportunity Now, Fiscal Policy Institute, Mar. 2017, [fiscalpolicy.org/wp-content/uploads/2017/03/Workforce-Report-.pdf](https://www.fiscalpolicy.org/wp-content/uploads/2017/03/Workforce-Report-.pdf).

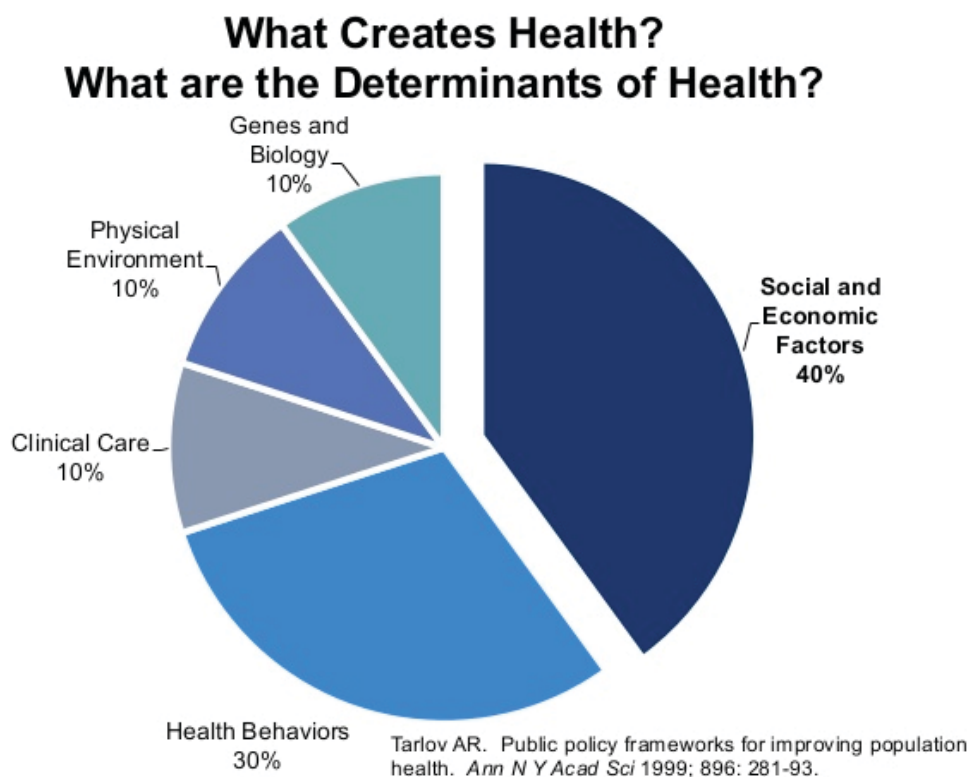
31 *Undervalued and Underpaid: How New York State Shortchanges Nonprofit Human Services Providers and their Workers*. Restore Opportunity Now, Fiscal Policy Institute, Mar. 2017, [www.fiscalpolicy.org/wp-content/uploads/2017/03/Workforce-Report-.pdf](https://www.fiscalpolicy.org/wp-content/uploads/2017/03/Workforce-Report-.pdf).

32 Id.

### III. UNDERSTANDING—AND SUPPORTING—HUMAN SERVICES CBOS' ROLE IN ADDRESSING SOCIAL DETERMINANTS OF HEALTH

New York State's shift to a value-based payment methodology was designed to significantly reduce fee-for-service arrangements and move towards coordinated and integrated care management that would result in better targeted care and cost-savings. While the State supported the health care delivery system in preparing and restructuring to meet the demands of this new system, human services CBOs received very limited help in making the transition to this new system. The State DSRIP program was funded at \$6.42 billion, yet as of the first quarter of DSRIP Year 3, only 0.4 percent of these funds (\$28 million) have flowed through the PPSs to human services CBOs.<sup>33</sup>

The path to improved outcomes and reduced costs starts at the critical intersection of health care payers, providers, and human services CBOs, and must be grounded in an understanding of—and support for—their role in addressing social determinants of health. Though much has been written about the need for greater integration between the health care delivery system and human services CBOs as trusted resources for social supports, bringing this integration to scale has proven difficult. The U.S. spends more on health care than any other industrialized country, yet it ranks 11th in overall health outcomes.<sup>34</sup> While there are many theories and viewpoints as to why this occurs, there is broad consensus that the social determinants of health are a key variable influencing individual and population health.



33 "Mid-Point Assessment Action Plans: PPS Progress through DY3, Q1." *New York State Department of Health*, Oct. 2017, [www.health.ny.gov/health\\_care/medicaid/redesign/dsrp/mid-pt\\_assessment/2017-10-30\\_mid-point\\_assess\\_update.htm](http://www.health.ny.gov/health_care/medicaid/redesign/dsrp/mid-pt_assessment/2017-10-30_mid-point_assess_update.htm).

34 Davis, Karen, et al. "Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally." June 2014, [www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror](http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror).

The World Health Organization defines social determinants of health as “the conditions, in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life.”<sup>35</sup>

The Robert Wood Johnson Foundation takes the World Health definition of social determinants of health further: “Factors such as where we live, how much money we have, our education level and the problems we struggle with have been clearly linked to our well-being, the quality of our lives, our health and how long we live.”<sup>36</sup>

For more than a century, human services CBOs have been on the front lines addressing the consequences of these conditions and their impact on people’s daily lives. VBP now requires that they demonstrate the value of this work as a direct pathway for achieving better outcomes and cost reductions.

Though many of the services offered by human services CBOs are small in scale, they offer a relatively low-cost “public good” to the health care system with a disproportionately large impact on health outcomes in communities. Social determinants include public goods such as access to safe housing and effective public transportation systems, and they are influenced by the supports and services provided by a vast network of human services CBOs through government funded contracts.

*A growing body of evidence reveals that investment in selected social services and partnerships between health care and social services can lead to substantial health benefits and reduce health care costs for targeted populations.*

As the system moves away from fee-for-service arrangements and there is greater realization that government contracts currently work against precepts of value-based care, we must create a much more coordinated and deliberate service network. Most health care providers are not equipped to address the effects of social and economic factors on their own but can leverage the expansive network of human services providers if we can develop referral and reimbursement mechanisms that make good business sense for both sides.<sup>37</sup> Human services CBOs are consummate builders of well-being because they:

- Know their clients;
- Have longstanding relationships that foster trust and collaboration;
- Understand the social constructs within which their clients live, work, learn, and play;
- Are well-trained and culturally competent; and
- Facilitate coordination and continuity of service.

Nationwide, the economy “benefits from long-term productivity increases due to the work of the human services ecosystem and also from the current economic activity represented by the roughly

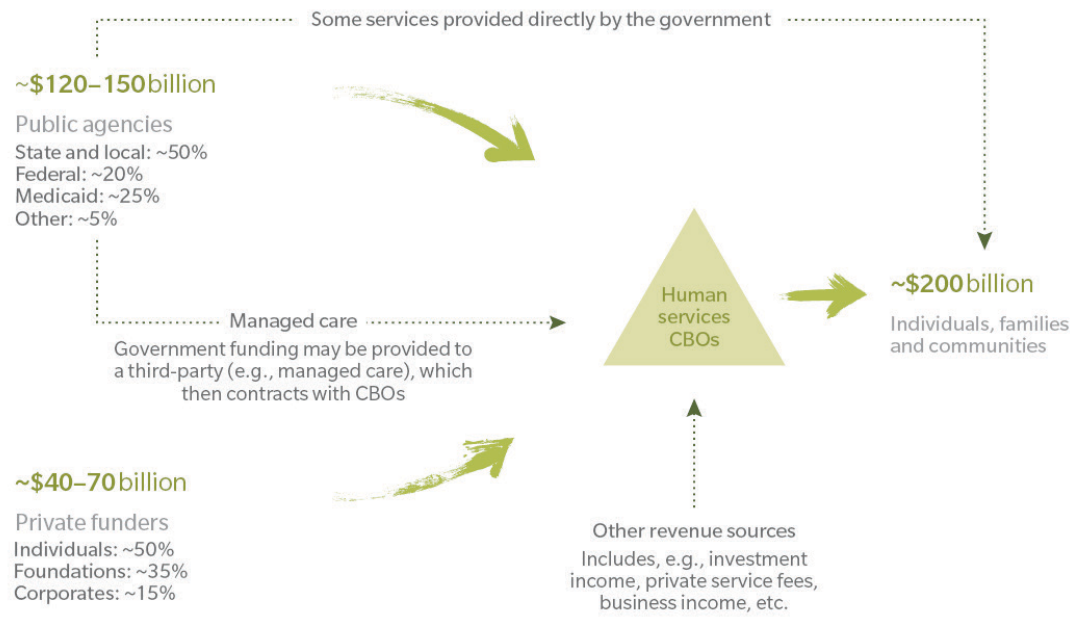
35 “About Social Determinants of Health.” *World Health Organization*, [www.who.int/social\\_determinants/sdh\\_definition/en/](http://www.who.int/social_determinants/sdh_definition/en/).

36 “Using Social Determinants of Health Data to Improve Health Care and Health: A Learning Report.” *Robert Wood Johnson Foundation*, 2 May 2016, [www.rwjf.org/en/library/research/2016/04/using-social-determinants-of-health-data-to-improve-health-care-.html](http://www.rwjf.org/en/library/research/2016/04/using-social-determinants-of-health-data-to-improve-health-care-.html).

37 Health care education should incorporate the research on SDH, and curricula should include the study of SDH and CBOs.

\$200 billion that human services CBOs spend per year on wages, benefits, rent, fuel, and all the other purchases necessary to run their organizations and to deliver services.”<sup>38</sup> The graphic below, taken from the *A National Imperative: Joining Forces to Strengthen Human Services in America* report, illustrates the size, funding structure, and impact of the human services sector nationally.<sup>39</sup>

Exhibit 2: Human services ecosystem key stakeholders and funding and expenditure flows



Source: National Center for Charitable Statistics (NCCS), Urban Institute, IRS Form 990 data, Oliver Wyman analysis  
 Note: These figures do not include the value of volunteer time and in-kind donations.

Human services CBOs are diverse. In addition to providing different services to different populations in diverse geographic and economic contexts, they vary greatly by budget size and revenue composition. Some organizations are very small, with budgets below \$500,000, while a few have budgets as large as \$250 million. These are complex entities that employ hundreds of professional staff and have sophisticated operations.

The makeup of human services CBO budgets varies substantially as well. For example, many human services CBOs that provide behavioral health services receive Medicaid payments, while others receive no Medicaid dollars. In addition, there can be variation within organizations. Human services CBOs that have multiple lines of business might receive Medicaid funding for some programs and have direct contracts with government or rely on philanthropy for others.

Like human services CBOs themselves, the individuals employed in the sector are diverse. Women account for more than 80 percent of the human services workforce, with women of color comprising

38 *A National Imperative: Joining Forces to Strengthen Human Services in America*. Oliver Wyman and SeaChange Capital Partners, 2017, [www.alliance1.org/web/resources/pubs/national-imperative-joining-forces-strengthen-human-services-america.aspx](http://www.alliance1.org/web/resources/pubs/national-imperative-joining-forces-strengthen-human-services-america.aspx).

39 Id.

41 percent of the total.<sup>40</sup> These workers are well-educated—41 percent have a four-year college degree, and 25 percent have an associates’ degree or have completed some college coursework.<sup>41</sup> Most work full-time or close to full-time schedules.<sup>42</sup>

Government policies and investments are a primary driver of the State’s human services sector. New York State is constitutionally obligated to provide for the public good,<sup>43</sup> and since the second half of the twentieth century, State agencies have largely relied on a vast and dynamic network of nonprofit organizations to meet this obligation throughout the State’s diverse communities. In 2016, New York State agencies held 4,400 contracts with nonprofit organizations.<sup>44</sup> As mentioned above, the sector employed more than 330,000 people statewide last year.<sup>45</sup> In fiscal year 2017, New York City agencies held human services contracts worth \$6.5 billion.<sup>46</sup>

Unfortunately, government contracts rarely cover the full cost of human services. In response to a survey conducted by the Nonprofit Finance Fund in 2015, 44 percent of human service providers reported that State contracts “never” covered the full cost of providing contracted services, while only seven percent indicated that State contracts “always” covered full costs.<sup>47</sup>

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40 *Undervalued and Underpaid: How New York State Shortchanges Nonprofit Human Services Providers and their Workers*. Restore Opportunity Now, Fiscal Policy Institute, Mar. 2017, [www.fiscalpolicy.org/wp-content/uploads/2017/03/Workforce-Report-.pdf](http://www.fiscalpolicy.org/wp-content/uploads/2017/03/Workforce-Report-.pdf). “In human services jobs other than child care, however, twice that share (41 percent) are women of color, and among child care workers, a slightly higher share (44 percent) are black, Latina, or Asian women.”

41 *Id.*

42 *Id.*

43 The State Constitution provides:

The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time determine.

Constitution of the State of New York, Article XVII, Section 1.

44 *Prompt Contracting Annual Report Calendar Year 2016*. Office of the New York State Comptroller, May 2017, [www.osc.state.ny.us/contracts/reports/2016/pcl\\_report.pdf](http://www.osc.state.ny.us/contracts/reports/2016/pcl_report.pdf).

45 In 2012, the latest year for which U.S. Bureau of Labor Statistics data were available, the sector paid about \$62 billion in wages statewide. The Fiscal Policy Institute found:

New York’s human services employment has doubled since 1990, increasing from 166,000 to 332,000 in 2016. In New York City, it rose by 82 percent, while the suburbs and upstate together saw 129 percent growth. Human services job growth occurred primarily among nonprofit organizations working under public contract, and was 21 percent of all private job growth in the suburbs and upstate, and 10 percent of New York City’s private job growth.

*Undervalued and Underpaid: How New York State Shortchanges Nonprofit Human Services Providers and their Workers*. Restore Opportunity Now, Fiscal Policy Institute, Mar. 2017, [www.fiscalpolicy.org/wp-content/uploads/2017/03/Workforce-Report-.pdf](http://www.fiscalpolicy.org/wp-content/uploads/2017/03/Workforce-Report-.pdf).

46 *Strengthening the Frontline: An Analysis of Human Services Contracts in NYC*. New York City Comptroller Scott M. Stringer, Office of the New York City Comptroller, 25 May 2017, [www.comptroller.nyc.gov/reports/strengthening-the-frontline-an-analysis-of-human-services-contracts-in-nyc/](http://www.comptroller.nyc.gov/reports/strengthening-the-frontline-an-analysis-of-human-services-contracts-in-nyc/).

47 “State of the Sector Survey.” *Nonprofit Finance Fund*, 2015, [www.nff.org/learn/survey](http://www.nff.org/learn/survey).

Science, data, and high rates of spending on health care have driven greater awareness on the part of government and health care providers about the role of human services CBOs and importance of social determinants of health. Now, in order for the State and health care system to better leverage this sector toward improving outcomes, the financial and structural stability of these providers must be reinforced.

The background features a stylized map with a grid of latitude and longitude lines. Two dark blue location pins are placed on the map, one in the upper right and one in the lower left. A large, dark blue rounded rectangle is centered on the page, containing the word 'APPENDICES' in white, bold, uppercase letters.

# APPENDICES



## APPENDICES

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### APPENDIX 1: THE CASE FOR COLLABORATION

This document presents some of the potential rewards, risks, and costs of participating in value-based payment arrangements for various stakeholders.

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### APPENDIX 2: SAMPLE SOCIAL DETERMINANTS OF HEALTH INTERVENTION MENU

This matrix is an example of a menu of interventions that address social determinants of health.

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### APPENDIX 3: MEASURES RECOMMENDATIONS

This document sets forth guiding principles and issues for consideration.

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### APPENDIX 4: LIST OF VALUE-BASED CARE COMMISSION MEMBERS

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### APPENDIX 6: LIST OF HSC BOARD MEMBERS

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### APPENDIX 7: LIST OF HSC STAFF



## APPENDIX 1: THE CASE FOR COLLABORATION

HSC's *A Call to Action* report sounded the alarm on the instability of New York's human services CBOs. The report indicated that the environment in which human services CBOs currently operate presents significant challenges to their sustainability. It points to specific government practices and policies that have undermined the fiscal health of these organizations and made it difficult for them to meet the growing need for their services. Both government and the health care industry must appreciate not only what human services CBOs have to offer, but also what their limitations and challenges are.

### Case for Collaborating with Health Care Providers under New Payment Opportunities (including Value-based Payment) for CBOs

<p><b>POTENTIAL POSITIVE OUTCOMES</b></p>	<ul style="list-style-type: none"> <li>• Better health outcomes</li> <li>• Reduced cost</li> <li>• Access to more beneficiaries</li> <li>• Increased health care billing (even if there is no new funding stream, networking can lead to more and better referrals for CBOs' existing funding streams)</li> <li>• Increased collaboration, learning, bartering, and sharing</li> <li>• Potential funding streams for services that are not necessarily direct services to consumers but make service better (e.g., training of doctors in residency or nurses to inform them about the populations that CBOs work with and the social determinants that affect them)<sup>48</sup></li> <li>• Sustainability of funds</li> <li>• Being part of a horizontal value chain rather than merely a vertical one</li> <li>• Performance-based metrics</li> <li>• Greater control</li> <li>• Being better networked and billing collectively as a consortium<sup>49</sup></li> <li>• Improved processes and programs—stronger ability to address social determinants</li> </ul>
<p><b>RISKS</b></p>	<ul style="list-style-type: none"> <li>• Not getting paid the full cost of service</li> <li>• Disruption of everyday workflow</li> <li>• Not being included in the selection of performance metrics</li> <li>• Being corporatized—there is value in CBOs' ability to engage with unique communities, but corporations prize standardization</li> <li>• Overly prescriptive metrics that do not necessarily correspond to the needs of the neighborhood</li> <li>• Static metrics—lack of feedback loop from the community that allows metrics to evolve over time</li> <li>• Mission creep</li> <li>• Need for faster outcomes—prevention is harder and longer to measure than acute treatment</li> <li>• Clinical care focus in agreements between CBOs and health care</li> </ul>
<p><b>COSTS/CAPACITY GAPS</b></p>	<ul style="list-style-type: none"> <li>• Data systems and trained staff</li> <li>• Relationship building and collaboration</li> <li>• Project management and governance</li> <li>• Implementation details (referral process, sharing of staff, training agenda, selecting meaningful outcomes, sharing results)</li> <li>• Up-front investment</li> <li>• Time</li> <li>• Distraction</li> <li>• Assessing risk</li> </ul>

48 Smaller CBOs might be interested in this but might not have the evidence base in order to support it.

49 Especially for smaller CBOs.

50 Especially for smaller CBOs.

## Case for Collaborating with CBOs under New Payment Opportunities (including Value-based Payment) for Health Care Providers

<b><i>POTENTIAL POSITIVE OUTCOMES</i></b>	<ul style="list-style-type: none"> <li>• Ability to address SDH</li> <li>• Better prevention of costly conditions</li> <li>• Better health outcomes</li> <li>• Reduced cost to achieve health outcomes</li> <li>• Better performance on value-based payment metrics – leading to enhanced revenue</li> <li>• Wider “offering” to patients (to include addressing social determinants)</li> <li>• Greater patient loyalty</li> <li>• Greater market share</li> <li>• Better integration with the community served</li> </ul>
<b><i>RISKS</i></b>	<ul style="list-style-type: none"> <li>• Lack of control over CBO services</li> <li>• Paying for ineffective services</li> <li>• Non-standardized services offered by multiple CBOs</li> <li>• Poor coordination between providers and CBOs</li> <li>• Mission creep</li> <li>• All of VBP means an enormous shift in business model (all incentives and all systems are built for a different model)</li> </ul>
<b><i>COSTS/CAPACITY GAPS</i></b>	<ul style="list-style-type: none"> <li>• Infrastructure for contracting required on both provider and CBO side (mostly non-existent – will require large up-front investment)</li> <li>• Data systems to track referrals and coordinate care (technology systems still inflexible)</li> <li>• Developing relationships between providers and CBOs</li> <li>• Ability to find, outreach, and deal with small CBOs</li> <li>• Cultural and language differences between providers and CBOs</li> </ul>

## Case for Government to Encourage Collaboration Between CBOs and Health Care Providers under New Payment Opportunities (including Value-based Payment)

<b>POTENTIAL POSITIVE OUTCOMES</b>	<ul style="list-style-type: none"> <li>• Better health outcomes</li> <li>• Reduced cost to achieve health outcomes</li> <li>• Achieving longer-term health gains for populations</li> <li>• Broader economic gains from a healthier population</li> </ul>
<b>RISKS</b>	<ul style="list-style-type: none"> <li>• If collaboration not successful, costs may increase without improving outcomes</li> <li>• Integration between providers and CBOs may create larger organizations with monopoly power to raise prices</li> <li>• Payments may be made for ineffective services</li> </ul>
<b>COSTS/CAPACITY GAPS</b>	<ul style="list-style-type: none"> <li>• New government infrastructure may be required for overseeing collaborations between CBOs and providers</li> <li>• Up-front investment may be required to support infrastructure on both provider and CBO side</li> <li>• New data systems may be needed to track patients across different settings</li> </ul>

## Case for Plans to Encourage Collaboration Between CBOs and Health Care Providers under New Payment Opportunities (including Value-based Payment)

<b>POTENTIAL POSITIVE OUTCOMES</b>	<ul style="list-style-type: none"> <li>• Better health outcomes</li> <li>• Reduced cost to achieve health outcomes</li> <li>• Achieving longer-term health gains for populations</li> <li>• Wider “offering” to plan participant patients (to include addressing social determinants)</li> <li>• Greater plan participant loyalty</li> <li>• Greater market share</li> <li>• Better integration with the community served</li> </ul>
<b>RISKS</b>	<ul style="list-style-type: none"> <li>• If collaboration is not successful, costs may increase without improving outcomes</li> <li>• Payments may be made for ineffective services</li> <li>• Integration between providers and CBOs may create larger organizations with monopoly power to raise prices</li> <li>• Lack of control over CBO services</li> <li>• Non-standardized services offered by multiple CBOs</li> <li>• Mission creep</li> </ul>
<b>COSTS/CAPACITY GAPS</b>	<ul style="list-style-type: none"> <li>• New plan infrastructure may be required for overseeing collaborations between CBOs and providers</li> <li>• Up-front investment may be required to support infrastructure on both provider and CBO side</li> <li>• New data systems may be needed to track patients across different settings</li> </ul>

**Case for Philanthropy to Support Collaboration Between CBOs and Health Care Providers under New Payment Opportunities (including Value-based Payment)**

<p><b>POTENTIAL POSITIVE OUTCOMES</b></p>	<ul style="list-style-type: none"> <li>• Better health outcomes at reduced cost</li> <li>• Integrating two priority areas of philanthropy – social services and health</li> <li>• Chance to make a sustainable difference (up-front investment to later be sustained by value-based payment)</li> <li>• Strengthening current grantees</li> <li>• Better serving the community</li> <li>• Ability to prove a model</li> <li>• Ability to leverage bigger dollars</li> </ul>
<p><b>RISKS</b></p>	<ul style="list-style-type: none"> <li>• Investment required may be larger than initially anticipated</li> <li>• Unsuccessful collaborations</li> <li>• May create greater dependency of grantees on philanthropy</li> <li>• If collaboration not successful, costs may increase without improving outcomes</li> <li>• Disruption of “market” forces</li> <li>• Dollars pale in comparison—“just a flea on an elephant”</li> <li>• Hard to show accountability/causality</li> </ul>
<p><b>COSTS/CAPACITY GAPS</b></p>	<ul style="list-style-type: none"> <li>• Philanthropy staff may not be well-versed in bridging the health care/CBO worlds</li> <li>• In addition to financial support, technical assistance may be needed for both providers and CBOs</li> <li>• Not enough is known on most effective ways of collaboration</li> <li>• Ability to measure/prove outcomes</li> <li>• Lack of understanding of health care system</li> <li>• Lack of experience with untested collaborations</li> </ul>

## APPENDIX 2: SAMPLE SDH INTERVENTION MENU

Sample Social Determinants of Health Intervention Menu		
Social Determinant Category	Essential Benefits	
	Community Initiative	Individual Intervention
Economic Stability	<ul style="list-style-type: none"> <li>• Job Opportunities</li> <li>• Living Wage</li> <li>• Public Assistance</li> <li>• Access to Health Insurance</li> </ul>	<ul style="list-style-type: none"> <li>• Employment Assistance (career planning, skills, job search, retention)</li> <li>• Support to Obtain or Recertify Benefits</li> </ul>
Neighborhood & Community Environment	<ul style="list-style-type: none"> <li>• Green Space</li> <li>• Accessible and Functional Public Transportation System</li> </ul>	<ul style="list-style-type: none"> <li>• Safe and Affordable Housing</li> <li>• Personal Safety (neighborhood, domestic)</li> <li>• Lead, Water Testing and Abatement</li> <li>• Heating or Cooling Assistance</li> <li>• Transportation for Activities of Daily Living and Health Care</li> <li>• Residential Retrofitting for Health Need</li> </ul>
Education	<ul style="list-style-type: none"> <li>• Safe &amp; Quality Schools</li> <li>• Early Childhood Education</li> <li>• Adult Education</li> <li>• GED</li> <li>• Vocational Counseling</li> </ul>	<ul style="list-style-type: none"> <li>• School Attendance Supports</li> <li>• Tutoring</li> <li>• Educational Advocacy – Special Education</li> <li>• Afterschool Activities and Services</li> </ul>
Food	<ul style="list-style-type: none"> <li>• Access to Quality Food</li> </ul>	<ul style="list-style-type: none"> <li>• Personalized/Therapeutic Meals</li> <li>• Skill Development Nutrition/Cooking for Wellness (Culturally Relevant)</li> </ul>
Community & Social Context	<ul style="list-style-type: none"> <li>• Civic Engagement</li> <li>• Community Building</li> <li>• Legal Services</li> <li>• Language and Mobility Supports</li> </ul>	<ul style="list-style-type: none"> <li>• Opportunities for Religious and/or Community Affiliation</li> <li>• Culturally and Age Relevant Health Activities (fitness group, book club, dominos group, peer support, AA, etc.)</li> <li>• Family System Support</li> </ul>
Health Care System	<ul style="list-style-type: none"> <li>• Aging in Place Capacity</li> <li>• Tele/IT-based Capacity for Community Management of Chronic Disease</li> </ul>	<ul style="list-style-type: none"> <li>• Home Health Care</li> <li>• Mobile Services</li> <li>• Care Management</li> <li>• Health Coaching</li> <li>• Wellness Check-in Services (respite, living room, settlement house, senior center, nurse-family partnership)</li> </ul>

## APPENDIX 3: MEASURES RECOMMENDATIONS

### HSC Value-based Care Commission Measures Workgroup Recommendations

#### Stakeholders

Measures should be developed with input from CBOs and ultimately should incorporate patient feedback.

#### Guiding Principles

Measures should be reasonably achievable and based on improved health outcomes. They should be developed in accordance with the following principles:

- Practical
- Reportable
- Actionable
- Incremental (beginning with actionable hot-spots and then expanding; starting with process and then moving to outcomes)
- Neutral with respect to organization size
- Person-centered
- Based on existing data and data systems
- Aligned with funding

Measures should also address patient engagement. Engagement includes hospitals working closely with the CBOs that they partner with so that the CBOs know how to engage the patients in their own care. Each handoff from hospital to CBO must be seamless, efficient, timely, transparent, and kind.

#### Interim vs. Long-term

Measures should account for the reality of time. In many cases, interventions that target social determinants of health take time to improve health outcomes. Accordingly, measures should be incremental. They should begin by addressing process and transition over time to focus on outcomes.

#### Evolution over Time

Measures should be assessed and, if appropriate, revised periodically to ensure that they keep pace with changing conditions over time. Changes in technology, community needs, research, funding, and other areas can influence provider capacity, as well as the relevance and effectiveness of interventions.

#### Funding

All parties responsible for gathering data must be funded adequately in order to do so. Funding must cover the cost of data collection and reporting (and analysis, if required).

## APPENDIX 4: LIST OF VALUE-BASED CARE COMMISSION MEMBERS

Lilliam Barrios-Paoli, former New York City Deputy Mayor of Health and Human Services  
Melinda K. Abrams, The Commonwealth Fund  
Charles A. Archer, The THRIVE Network  
Heath Bloch, SCO Family of Services  
Joann Casado, Children's Aid  
Steve Coe, Community Access  
Donna Colonna, Services for the UnderServed  
Tara Colton, Seedco  
Margaret Crotty, Partnership with Children  
Lisa David, Public Health Solutions  
Bruce Feig, Sachs Policy Group  
Neil Pierson Flynn, Brooklyn Community Services  
Kristin Giantris, Nonprofit Finance Fund  
Kerry Griffin, The New York Academy of Medicine  
Kathryn Haslanger, JASA  
Natasha Lifton, The New York Community Trust  
Joan Malin, former Executive Director, Planned Parenthood of New York City  
Pamela Mattel, Acacia Network  
Nancy D. Miller, VISIONS/Services for the Blind and Visually Impaired  
Nora Moran, Safe Horizon, formerly of United Neighborhood Houses  
Alan Mucatel, Leake and Watts Services  
Justin Nardilla, CAMBA  
Mitchell Netburn, Project Renewal  
Christy Parque, The Coalition for Behavioral Health  
Elizabeth Perez, Lawyers Alliance for New York  
Jorge R. Petit, Coordinated Behavioral Care  
Scott Pidgeon, Beacon Health Options  
Rachael N. Pine, Altman Foundation  
Michael Hamill Remaley, Philanthropy New York  
Allison Sesso, Human Services Council of New York  
Anthony Shih, United Hospital Fund  
Joan Siegel, Good Shepherd Services  
Arthur Webb, Arthur Webb Group  
Susan Wiviott, The Bridge

## APPENDIX 5: OVERVIEW OF COMMISSION WORKGROUPS

### HSC Commission on Value-based Care: Workgroup Subjects

HSC's Commission on Value-based Care was established to explore the implications of value-based payment for the nonprofit human services sector and to make recommendations as to how human services can best be integrated with the health care system. Ultimately, the Commission's goal was to achieve the State's "Triple Aim" of reduced cost, better care, and better outcomes. Chaired by former New York City Deputy Mayor for Health and Human Service Lilliam Barrios-Paoli, the Commission was comprised of leaders with experience and expertise spanning government, health care, philanthropy, academia, and human services. These experts carried out their work largely through four smaller workgroups, which convened between full Commission meetings to address specific areas of implementation. At full Commission meetings, the groups shared information and findings to identify common themes. The groups are described below.

#### **Making the Case**

Chair: Jorge Petit, M.D., CEO of Coordinated Behavioral Care

This group was committed to demonstrating the role that human services can play in improving outcomes and achieving shared savings. The group also identified risks, rewards, and prerequisites for participation by community-based organizations (CBOs) in the value-based payment (VBP) model, with the goal of helping CBOs understand whether they are positioned to participate effectively.

#### **Articulating the Service Structure**

Pamela Mattel, COO of Acacia Network

Once the "case" is made that human services are essential to achieving the "Triple Aim," it is necessary to ensure that implementation is effective. The Articulating the Service Structure workgroup produced a sample menu of interventions, based on existing examples, that are most likely to produce positive outcomes. This group's work centered on social determinants of health and the interventions that are known to have a significant impact on them.

#### **Measures**

Arthur Webb, Principal of Arthur Webb Group

At the heart of VBP is paying for outcomes rather than paying for inputs. Thus, the Measures workgroup addressed the questions of what to measure and how. The group developed a set of principles that can be applied to measures for all CBO services. The group also examined existing measures to determine whether they are appropriate for interventions that address social determinants of health. The measures are categorized according to the social determinants of health identified by the Articulating the Service Structure workgroup.

#### **Financial Terms and Contractual Models**

Bruce Feig, Healthcare Consultant at Sachs Policy Group

Acknowledging that most CBOs that participate in VBP will be entering the system at a fiscal disadvantage, this group worked to ensure that payment of CBO services is adequate and structured in a way that truly fosters achievement of the Triple Aim. The group explored financial approaches such as gains sharing, front-end balloon payments, and subcontractor arrangements in order to distribute risk fairly. The group also considered the possibility of standard contract language that could be used by all CBOs.



## APPENDIX 6: LIST OF HSC BOARD MEMBERS

Chair: Jeremy Kohomban, The Children's Village

Vice Chair: Frederick Shack, Urban Pathways

Treasurer: Mitchell Netburn, Project Renewal

Secretary: Dianne Morales, Phipps Neighborhoods

Louisa Chafee, UJA-Federation of New York

Margaret Crotty, Partnership with Children

Julissa Ferreras-Copeland, Former New York City Councilmember

Nathaniel Fields, Urban Resource Institute

David Garza, Henry Street Settlement

Katy Gaul-Stigge, Goodwill Industries of Greater New York and Northern New Jersey

Christina Greer, Fordham University

Mark Hoenig, Weil, Gotshal & Manges LLP

Karen Spar Kasner, Member at Large

Thomas Krever, Hetrick-Martin Institute

Maria Lizardo, Northern Manhattan Improvement Corporation

Sr. Paulette LoMonaco, Good Shepherd Services

Ronald Richter, JCCA

Gustavo Schwed, NYU Stern

Ariel Zwang, Safe Horizon

## APPENDIX 7: LIST OF HSC STAFF

Allison Sesso, Executive Director  
Michelle Jackson, Deputy Director & General Counsel  
David Ng, Government & External Relations Manager  
Tracie Robinson, Senior Policy Analyst  
Luis Saavedra, Executive Assistant  
Omar Smiley, Manager of Strategic Initiatives  
Iona Tan, Communications Associate  
Jason Wu, Membership Services Manager



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