



Improving Contracting between Human Services and Health Care Organizations:

Recommendations from a Cross-Sector Collaborative

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Section 1: Background

Human services community-based organizations (CBOs) address health-related social needs and social determinants of health daily, with services such as emergency food assistance, housing assistance, health coaching, and countless others. As health care organizations (HCOs), such as hospitals, health systems, and community health centers, and managed care organizations (MCOs), have increased recognition of the importance of integrating human and health services, the demand for CBO services has increased and CBOs are being asked to modify operations and capabilities to meet the needs of the health care system and its patients. Despite the demands being placed on the CBO sector, contracts to support and sustain CBO services have been limited.

The New York State Department of Health’s (DOH) Value-Based Payment (VPB) program has certain requirements for HCOs and MCOs to contract with CBOs to address social needs. However, due to various barriers and operational challenges, contracting has been limited and CBOs continue to lack a sustainable source of funding for programs that result in savings or benefits to the health care sector. Despite the lack of contracting, CBOs, which provide invaluable services to their communities, continue to be approached to develop and participate in new programs, pilots, and other projects that often lack clear sustainability plans.

To identify and address the challenges related to CBO contracting, the Human Services Council partnered with Greater New York Hospital Association to convene the *Human and Health Services Collaborative*, a cross-stakeholder group that aimed to identify and address the challenges in developing CBO/MCO and CBO/HCO contracts. This collaborative included representatives from CBOs, health systems, and MCOs serving Brooklyn who discussed experiences and successes with contracting and offered insights from their sectors on creating viable partnerships with sustainable funding models.

Based on *Collaborative* discussions, HSC has developed a set of recommendations to facilitate cross-sector contracting and sustain the human services organization activities that provide value to health care providers and plans. The recommendations describe activities that CBOs should complete prior to approaching HCOs and MCOs about contracting opportunities, recommendations for MCOs and HCOs during contracting, and considerations for joint intervention design. See Table 1 for an overview of the recommendations that are further detailed in the report.

TABLE 1: SUMMARY OF RECOMMENDATIONS TO IMPROVE CONTRACTING BETWEEN HEALTH & HUMAN SERVICES

Recommendations for CBOs
Become informed about HCO and MCO priorities, including certain regulatory and financial requirements that could impact contracting success.
Research the evidence-base for your intervention or offer to work collaboratively to develop the evidence to demonstrate how CBO services can result better health outcomes.
Review your budgets, especially the full cost of services, including indirect costs and staff and infrastructure needed for reporting and communication requirements that may be part of the future contract.

Recommendations for HCOs

Evaluate the impact of CBO services on health care outcomes.

Consider contracting for small scale, high-impact interventions.

Minimize reporting requirements and consider supporting data collection and measurement.

Considerations for Joint Intervention Design

Engage community networks, members, and stakeholders, including CBO partners, for feedback and consideration when developing interventions to ensure that community needs are met.

Align on definitions, parameters, and population served.

In addition to these contracting recommendations, this report also reviews unresolved challenges that require policymaker and government attention as they seek improve human and health services integration.

Section 2: Recommendations for CBOs

1. Become informed about HCO and MCO priorities, including certain regulatory and financial requirements that could impact contracting success.

Prior to approaching HCOs or MCOs in an effort to enter into contracting discussions, it is important for CBOs to understand the way that the health care sector functions. In particular, it is useful to be aware of how HCOs and MCOs are funded and incentivized. This prepares CBOs to formulate an approach that resonates with the HCO or MCO and aligns with their priorities. With proper context, CBOs can be better prepared to approach MCOs and HCOs using language and proposals that may be initially appealing and facilitate initial conversations.

While CBOs are not expected to be experts on health care policy and reimbursement, it is helpful to have a basic knowledge in certain topics. Table 2 lists educational resources for CBOs that provide basic-level information on areas that are important to HCOs and MCOs.

TABLE 2: EDUCATIONAL RESOURCES ON HCO AND MCO TOPICS

Basics of health care reimbursement and funds flow	Hospital reimbursement https://www.aha.org/system/files/2018-01/factsheet-hospital-billing-explained-9-2017.pdf
	Information about Medicaid Managed Care https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/
Privacy laws and information-sharing between organizations	Summary of Health Insurance Portability and Accountability Act https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html
	HIPAA for Care Coordination https://www.hhs.gov/hipaa/for-professionals/faq/3014/uses-and-disclosures-for-care-coordination-and-continuity-of-care/index.html
	Privacy principles for non-HIPAA-covered entities https://www.ama-assn.org/system/files/2020-05/privacy-principles.pdf
Quality incentive programs	Pay for performance in health care https://catalyst.nejm.org/doi/full/10.1056/CAT.18.0245
	Quality requirements for MCOs https://www.macpac.gov/subtopic/quality-requirements-under-medicaid-managed-care/

About Health Care Quality Measures

HCOs and MCOs are required to report Healthcare Effectiveness Data and Information Set (HEDIS) measures. HEDIS is one of health care's most widely used performance improvement tools and is used to identify opportunities for improvement, monitor the success of quality improvement initiatives, and track improvements. HEDIS includes more than ninety measures across six domains of care. Measures that are particularly important in primary and managed care are related to prevention and screening, access and availability of care, and utilization.

To improve HEDIS scores, HCOs and MCOs often have strategies in place to help patients and members manage their health and continuity of care. For example, low preventive screening and patient engagement rates can prevent HCOs from raising their scores and limit earnings.

CBOs are primed to connect with individuals who are lost to health care follow up and engage them in healthy behaviors. CBOs can propose outreach and engagement activities to HCOs and MCOs, specifically in the context of improving HEDIS scores. These activities are valuable to MCOs and HCOs which often earn financial incentives for engagement, preventive care, and chronic disease care.

CBOs seeking to partner with health care providers and plans should develop a familiarity with clinical measures that align with their interventions. Examples of this alignment are listed in Section 3. CBOs can use this knowledge to highlight expected behavior changes from the interventions and make connections to potential health care outcomes.

2. Review the evidence-base for your intervention or offer to work collaboratively to develop the evidence to demonstrate how CBO services can result in better health outcomes.

There is an existing and growing body of evidence that CBOs can reference when asked to demonstrate their impact on health outcomes and value to HCOs. CBO interventions impact behavior change, as well as behavioral health and chronic disease symptoms. Table 3 lists a collection of relevant published studies, the publication where the study was printed, and examples of relevant CBO services and health care measures to help CBOs think about the direct impact their services can have. The listed services and measures include those referenced in the articles, as well as others that are presumed to be relevant. Many of the articles reference others that also demonstrate the links between addressing social needs and improved health outcomes.

Better Maternal Infant Care

Brooklyn Perinatal Network (BPN), in collaboration with Healthfirst and Maimonides Medical Center, explored opportunities to deploy an evidenced-based program called the Pathways Community HUB Initiativeⁱ for women and families in Brooklyn. This model aims to achieve better client experiences and maternal health outcomes by improving health knowledge and service quality while coordinating care with medical providers. BPN has engaged in training to adopt the Pathways Agency Certified program model to implement the Downstate DOH First 1,000 Days on Medicaid Maternal Infant Care pilot project and will bring portions of this model to a contract with Healthfirst to promote better access and utilization of health resources, mitigate vulnerabilities and address social determinants of health.

TABLE 3: PUBLICATIONS ON EVIDENCE BETWEEN CBO SERVICES & IMPACT ON HEALTH CARE

Title	Publication	Examples of Relevant CBO Services	Examples of Relevant Health Care Measure Areas
The Threat of Home Eviction and its Effects on Health through the Equity Lens: A Systematic Review	Social Science & Medicine	Housing navigation; Eviction prevention; Legal services	Mental health outcomes; Chronic disease outcomes; Utilization measures
Demonstrated health care cost savings for women: findings from a community health worker intervention designed to address depression and unmet social needs	Archives of Women’s Mental Health	Community health worker services; Mental health screening; Prenatal support; Doula services	Cost of care; Utilization measures; Post-partum measures
Cost-effectiveness of Leveraging Social Determinants of Health to Improve Breast, Cervical, and Colorectal Cancer Screening	Journal of the American Medical Association (JAMA) Oncology	Community health worker services; Health care navigation; Insurance enrollment; Transportation services	Cancer screening rates; Cost of care
Foods for health: An integrated social medical approach to food insecurity among patients with diabetes	American Journal of Health Promotion	Emergency food; Nutrition education; Other food access	Diabetes measures (Hb A1C level)

Title	Publication	Examples of Relevant CBO Services	Examples of Relevant Health Care Measure Areas
Evaluation of a National Care Coordination Program to Reduce Utilization Among High-cost, High-need Medicaid Beneficiaries With Diabetes	Medical Care (American Public Health Association)	Benefits enrollment (Medicaid, Temporary Assistance for Needy Families, Supplemental Security Income); Care coordination	Utilization measures (hospitalizations and emergency department (ED) visits)
Financial Support to Medicaid-Eligible Mothers Increases Caregiving for Preterm Infants	Maternal and Child Health Journal	Financial support; Prenatal support and education; Doula services	Increased breastfeeding
Unmet Social Needs and No-Show Visits in Primary Care in a US Northeastern Urban Health System, 2018–2019.*	American Journal of Public Health	Transportation; Housing assistance; Food assistance; Financial assistance	Appointment show rates; Utilization measures; Primary care measures
Impact of complex care management on spending and utilization for high-need, high-cost Medicaid patients	American Journal of Managed Care	Care management; Outreach and engagement	Utilization measures (hospitalizations and ED visits)
Return on Investment From Co-locating Tax Assistance for Low-Income Persons at Clinical Sites*	JAMA	Tax preparation services	ROI associated with co-located services
Changes in Medicaid Utilization and Spending Associated with Homeless Adults' Entry into Permanent Supportive Housing	Journal of General Internal Medicine	Housing navigation; Supportive housing; Housing assistance	Utilization (hospitalizations and ED visits, residential behavioral health)

*Note: These articles were published by researchers from New York City hospitals.

CBOs can also refer to the University of San Francisco California’s Social Intervention Research and Evaluation Network’s (SIREN) [Evidence & Resource Library](#) for peer-reviewed publications and other resources on medical and social care integration. Where the evidence does not exist, CBOs should be open to contributing to the evidence in partnership with HCOs and MCOs that have evaluation resources.

3. Review your budgets and understand potential payment models.

Given CBOs' financial challenges, it is important to consider budgets and document the cost of services, including indirect costs, so the full-service costs are covered, including outreach, engagement, administration, legal, cost escalation, and IT infrastructure. This may also include the staff and infrastructure needed for reporting and communication requirements that may be part of the future contract. It is important to note variable costs that may increase with the number of services provided such as fuel for transportation, utilities, supplies, and wages. Contracts that span multiple years should consider inflation and other cost increases. Being certain of all the necessary costs of entering into an MCO or HCO contract helps the CBOs request funding that covers those costs. Contract terms that exclude certain costs can then be carefully considered by the CBO.

Budget and Financial Planning Resources

Organizations across the country have developed tools and resources for CBOs to support financial literacy and related decision-making.

- Key performance indicators (KPIs) were developed by HSC's Closures Commission's Financial Conditions Committee through the [Standards for Nonprofit Financial Reporting](https://humanservicescouncil.org/wp-content/uploads/Initiatives/HSCCommission/Commission-Report-Appendices.pdf). <https://humanservicescouncil.org/wp-content/uploads/Initiatives/HSCCommission/Commission-Report-Appendices.pdf>
- [The SCAN Foundation](https://www.thescanfoundation.org/resources-tools/) partnered with the Health Foundation for Western & Central New York to develop a series of online educational modules, ROI calculators, budget and financial planning resources, and pricing guide for CBOs. <https://www.thescanfoundation.org/resources-tools/>
- The Wallace Foundation, in association with Fiscal Management Associates, developed the [Strong Nonprofits Toolkit](https://www.wallacefoundation.org/knowledge-center/resources-for-financial-management/pages/default.aspx) to help CBOs with budgeting, cash flow, operations, data and analysis, audit readiness, and governance and strategy. <https://www.wallacefoundation.org/knowledge-center/resources-for-financial-management/pages/default.aspx>
- [Nonprofit Works](https://www.nonprofitworks.com/resources/) lists a number of resource materials for CBOs in their planning, budgets, fund development, communication, and governance. <https://www.nonprofitworks.com/resources/>
- [BDO Institute for Nonprofit Excellence](https://www.bdo.com/resource-centers/institute-for-nonprofit-excellence/fasb-financial-reporting) issued standards for nonprofit financial reporting. <https://www.bdo.com/resource-centers/institute-for-nonprofit-excellence/fasb-financial-reporting>

In addition to reviewing expenses against internal budgets to document the actual costs of services, CBOs must also understand how HCOs and MCOs might pay for contracted services. HCOs in particular are often subject to different types of payment models, including value-based payment (VBP) models where they assume some level of financial risk based on the costs and quality of care provided to their patients. Both HCOs and MCOs may attempt to pass on a certain amount of risk to CBOs, which should be very carefully considered.

As part of their VBP contracts, HCOs and MCOs typically track expenditures, quality, and utilization to monitor performance. Requirements associated with these performance measures may also be passed down to CBOs as part of a contract. Contracts with tracking, data collection, and reporting requirements should also be carefully considered, particularly in the event that a CBO does not have the internal financial, analytical, or human resource capabilities to meet such requirements.

VBP Resources

GNHYHA developed a publicly available VBP curriculum to support contracting efforts under Delivery System Reform Incentive Payment (DSRIP). It includes an overview of types of payment models, funds flow models, and the CBO role in VBP. The curriculum is available here: <https://www.gnyha.org/tool/value-based-payment-fundamentals-a-guide-to-new-york-state-medicaid-vbp/>.

In addition to these recommendations, there are other considerations for CBOs prior to entering into a contract. CBOs are encouraged to:

- Consider whether the services provided are aligned with the CBO's mission.
- Understand organizational and financial capabilities and sustainability to determine if it is reasonable to change CBO operations to accommodate MCO or HCO requirements of the MCO.
- Develop the bandwidth and internal organizational competencies to scale up operations before participating in a contract or negotiate with the MCO to make additional investments into the CBO.
- Consider the IT infrastructure and staff needed for data collection, storage and sharing, and measuring and evaluating outcomes, and think about whether the HCO or MCO can support these activities with their resources and expertise.
- Determine the obligations and terms of the contract, including defining payment terms, timeframes, conditions for the contract to be terminated, and how to handle disputes.
- Consider the frequency of timing of payments, outcomes and deliverables, data and confidentiality agreements, and how progress is monitored.
- Determine if there are any incentives or penalties in the contract and assess the financial impact on the organization.

Section 3: Recommendations for HCOs & MCOS

1. Consider the value of the services CBOs can provide, not traditionally covered by Medicaid, to their members for better community health.

CBOs are at the frontlines of communities and can be valuable partners to MCOS and HCOs aiming to address patients’ holistic needs. CBOs connect with hard-to-reach populations and members who are lost to health care follow-up. They also understand barriers individuals and families face in accessing health care, as well as the other issues – transportation, language access, housing – that make follow-up difficult. CBO services can increase health efficacy by ensuring people have access to nutritious food and safe housing, and can help reinforce health instructions and the importance of health care in general with the people with whom they work. The services provided by CBOs have critical connections to health care outcomes. Table 4 lists examples of CBO services that can help improve scores on HEDIS measures. Most of these services are not covered by Medicaid or other health care payers.

TABLE 4: EXAMPLE HEDIS MEASURES POTENTIALLY IMPACTED BY CBO SERVICES

HEDIS Measure	Example CBO Services
<u>Comprehensive Diabetes Care</u> : Requires health care providers to assess adult patients with type 1 and 2 diabetes and ensure patients control blood glucose (HbA1c), blood pressure, and other diabetes-related complications.	<ul style="list-style-type: none"> - Culturally sensitive diabetes education - Assistance with medication adherence - Nutrition education and assistance - Smoking cessation services - Medically tailored meals - Food assistance
<u>Adults’ Access to Preventive/Ambulatory Health Services</u> : Tracks the percentage of Medicaid and Medicare members who had an ambulatory or preventive care visit during the measurement year.	<ul style="list-style-type: none"> - Transportation to medical appointments - Health literacy education - Care coordination and case management - Assistance with child care and other services that may prevent patients from getting to routine medical appointments
<u>Prenatal and Postpartum Care</u> : Assesses the percentage of prenatal visits in the first trimester and postpartum care visits between 7 and 84 days after delivery.	<ul style="list-style-type: none"> - Children and family services - Parenting support - Pregnancy-related education - Care coordination and case management - Women’s support services - Domestic violence interventions
<u>Fall Risk Management</u> : Assesses providers’ fall risk management for Medicare beneficiaries 65 and older with balance, walking problems, or a fall in the past 12 months, who report discussing these problems with their provider and report receiving fall risk intervention from the provider.	<ul style="list-style-type: none"> - Mobility and rehabilitation services - Home visits - Respite services - Senior support - Caregiver support
<u>Behavioral health</u> : Follow-up after hospitalization for mental illness, identifies the percentage of members 6 years of age or older who received follow-up within 7 and 30 days of discharge.	<ul style="list-style-type: none"> - Home and Community-Based Services - Care management - Wrap-around social services

Certain services are overarching and improve outcomes more generally, such as cultural and linguistically appropriate care and communication.

Enhanced Service Coordination & Navigation

In 2020, Public Health Solutions (PHS) and Healthfirst piloted a service coordination and navigation program funded by the New York State AIDS Institute as part of their Ending the Epidemic initiative. This program connects traditionally hard-to-reach members living with HIV/AIDS to a diverse range of services provided by community-based partners, such as food insecurity resources, housing support, and mental health services. PHS worked closely with Healthfirst to identify the target population, co-creating an assessment process that uses a person-centered approach, which allows the member to express and prioritize their own social and/or medical needs with support from the PHS team. PHS conducted telephonic outreach to 4,400 Healthfirst managed care members. Of the 1409 reached, screened, coached, or navigated for up to six months, viral suppression rates were improved. PHS and its downstream CBO affiliates including Alliance for Positive Change, Riseboro, JASA, BronxWorks, and La Nueva Esperanza, received payment from Healthfirst for these services and the contract was recently renewed for a second year.

2. Consider small scale, high-impact interventions.

CBOs provide many niche services to small populations that are often not reached by other means. This is especially the case with CBOs that serve specific neighborhoods, people who speak a particular language, people with specific conditions, and other defined populations. However, individuals served by these CBOs are often the hardest to reach, and though the scale of a potential intervention is small, it could have a higher impact or be combined with other services for a higher impact.

Of note, small CBOs, or CBOs that serve a niche population, have much less contracting leverage in an already uneven playing field where MCOs and HCOs have increased power. When contracting with a CBO, it is important to consider how there can be more equitable terms that cover the CBO's program or intervention costs.

VISIONS: An Example of High-Value Services for a Specific Population

VISIONS/Services for the Blind and Visually Impaired is a nonprofit vision rehabilitation and social service organization. VISIONS develops and implements individualized programs to assist people who are blind and visually impaired of all ages to lead independent and active lives. In addition to serving individuals, VISIONS has also developed education and training programs for health care and hospital staff who work with patients who are blind or visually impaired, including discharge planners, with protocols on how to make a referral for in-home and community training for this population.

While people who are blind receive health care services covered by Medicare, Medicaid, or disability insurance, specialized vision rehabilitation services, including vision rehabilitation therapy for training in daily living skills and orientation and mobility instruction for safe navigation and falls prevention, are not covered by Medicare or Medicaid, nor are the specialized devices or adaptive equipment such as the long red and white mobility cane. People with low vision who are not considered legally blind lack New York State funding that pays for specialized training in daily living skills, navigating outdoors, and counseling for adjustment to their vision loss.

Research has demonstrated that people with blindness and low vision have increased health care costs, including length of stay and readmissions, as well as health care risks such as falls, injuries, depression, and other behavioral health diagnoses. Despite documented benefits for services that address these concerns, VISIONS has been challenged with identifying HCOs and MCOs that are willing to compensate the organization for its services for low vision patients, in part due to the niche population they serve and the lack of New York State licensure of vision rehabilitation therapists and orientation and mobility specialists.

3. Minimize reporting requirements and consider supporting data collection and measurement.

Significant reporting requirements can create unnecessary burden on CBOs. It is not uncommon for CBOs to be asked for information by their health care partners that is not routinely collected, which can cause operational barriers for the CBO and barriers for those seeking care. As part of agreed-upon programs, HCOs and MCOs should seek simple or minimal reporting that is consistent with the capabilities, reporting systems, and data gathering already in place at the CBO. HCOs and MCOs should recognize that many CBOs ask their clients for very minimal data and clients may be wary of information gathering that they do not understand. Some services are delivered anonymously to preserve client dignity and privacy. Additionally, because services are often provided regardless of an individual's ability to pay, insurance information is not typically collected.

CBOs often receive grant funding from various sources which have varying reporting and documentation requirements and use different systems to capture information. In turn, CBOs must track different metrics across populations and report data to numerous systems without bidirectional data sharing. This adds administrative burden on CBOs and causes fragmented data and a lack of interoperability at all levels.ⁱⁱ Additionally, certain reporting may require IT infrastructure and interoperability, which CBOs may not have in place and may need support or funding to be able to do.

Improved Referral Management

Beacon, a health plan for behavioral health services, reached out to Catholic Charities Neighborhood Services (CCNS) looking to link CCNS to Queens Hospital Center to help manage referrals from their Psychiatric In-Patient Units and the Psyche Emergency Room Dept. Weekly Zoom meetings were set up between CCNS, Queens Hospital, and Beacon to discuss streamlining and fast-tracking the referral process. CCNS and Queens Hospital also wanted to work on improving the current Urgent Care follow-up process for referrals that did not show up for their intake upon discharge from the hospital. After a month of discussions, a final workflow and referral process was put in place that allows real-time communication between CCNS and Queens Hospital regarding high-risk clients who do not comply with out-patient intake, which improved client engagement and follow-up of non-compliant high-risk referrals. These activities fall under a linkage agreement for which there is no payment associated.

Section 4: Considerations for Joint Intervention Design

1. Engage community networks, members, and stakeholders when developing interventions to ensure that community needs are met.

It is important to consider community needs when developing interventions. Existing reports and data, such as hospital community health needs assessments and New York City Department of Health & Mental Hygiene data, can be useful. HCOs and MCOs should also look towards existing community networks and coalitions for feedback, as these are typically comprised of people living within the community who can speak specifically to the needs that exist. Where cross-sector groups exist, there may be built-in community engagement, feedback, and decision making on program design and definitions of success.

Connecting to an existing cross-sector structure, or creating one if it does not exist, can strengthen partnerships and ensure gaps in community needs are filled. Examples of this infrastructure, sometimes called Accountable Communities for Health,ⁱⁱⁱ are catalogued by the George Washington University School of Public Health: <https://accountablehealth.gwu.edu/ACHInventory>.

Increased Transportation Options

Restoration's Center for Healthy Neighborhoods has been leading the [NYC Better Bike Share Partnership](#) in collaboration with Motivate, the operators of the Citi Bike program, NYC Department of Transportation (DOT), and NYC Department of Health and Mental Hygiene (DOHMH) since 2015, which aims to promote equity in access to and use of bike share in order to improve transportation options, access to physical activity, and economic opportunities. Restoration was funded by the Better Bike Share Partnership, received early in-kind support from the DOT and DOHMH, and obtained grant funding from DOHMH. Restoration also helped facilitate the Reduced Fare Bike Share Program (RFBS) sponsored by Healthfirst which in 2018 expanded the heavily discounted \$5/month Citi Bike membership to all SNAP recipients in NYC. Restoration continues to seek funding to completely cover these services for low-income residents, similar to government subsidies that cover public transportation for eligible individuals.

An Accountable Community of Health in Brooklyn, NY

Brooklyn's Community Action and Advocacy Workgroup (CAAW) is a model for cross-sector collaboration that identifies community needs through direct community input and develops strategies and interventions that address those needs. Started by the Community Care of Brooklyn, the Maimonides Medical Center-led performing provider system implementing New York State's Delivery System Reform Incentive Payment program, the CAAW convenes Central Brooklyn community leaders, and representatives from CBOs, hospitals, MCOs, community health centers, and other stakeholders.

Together, the group developed a series of participatory action research (PAR) projects that engaged community members at all levels of implementation. The projects included community residents, high school and college students, as well as local organizations and elected officials, in the research design, implementation, and report development. Resulting from those projects were initiatives that were recommended by the community and that prioritized community needs. Investments in projects such as care management connections, hydroponic farms at local schools, workforce programs, and other initiatives were driven by community engagement, and addressed specific needs in a measurable way.

Since 2016, the CAAW has been meeting approximately every two months to provide the participants with updates on ongoing PAR work and the resulting initiatives, which have continued and evolved since the group's inception. The CAAW serves as a forum for cross-sector stakeholders from the local community to strategize jointly on investments, priorities, and projects that will have a lasting impact, while developing trust and relationships.

2. Align on definitions, parameters, and population served.

When contracting CBOs and their HCO or MCO partner are discussing interventions, it is important to align on the language used and the population served. The health and human services sectors use their own respective terms to describe conditions, groups of people, and goals. While the terms can differ, there are often opportunities to align on language or provide explanations or context as to what a term describes. This is particularly important, as MCOs and HCOs tend to use clinical language that is not always understandable to other professionals, and more importantly, lay people in the communities they serve. There should be a partnership to develop shared language and crosswalk the different ways of describing their services, goals, and intended outcomes and creating clinical goals and related language easy to understand for those in non-clinical roles.

The following are examples of terms or populations that need to be agreed-upon as part of programs or services:

Population-based terms

- **Homeless:** this term can refer to people who experience street homelessness, or who live in a shelter. The term generally excludes people at-risk of homelessness and may also exclude people who have somewhere to live (such as with a relative or a friend), but do not have stable housing. If

developing programming or interventions related to housing, the population served should be very clear.

- **Chronically ill:** this term can be used for people living with chronic diseases. It often refers to people living with diabetes, hypertension, congestive heart failure, asthma, and other chronic conditions that can be managed between a primary care provider and particular specialists. However, chronic conditions go far beyond these descriptions, and the term should be specified early in discussions with specific diagnoses or conditions that are of interest to the contracting parties and the communities they serve.

Age-based terms

- **Adult:** can be defined as people aged 18 or older or aged 21 or older. The term *young adult* is sometimes used to define people within a particular age group, but those ages are not standardized across organizations or sectors.
- **Older adult:** the Older Americans Act classifies people aged 60 or older as *older adults*, while the Medicare program serves people 65 and older. Certain programs may focus on people who are older than these two definitions, as health risks may increase with age.
- **Youth:** pediatrics practices may serve children until they reach 18, and those that also treat adolescents may serve patients until they reach the age of 21.

In addition to awareness around terms that vary, there are certain terms that should be avoided as they are vague and do not specifically define a population to be served. The terms *vulnerable* and *high-risk* are often used to describe large populations of people with both health and socioeconomic concerns. For the purposes of defining a population, it is best to be specific about expectations and to come to an agreement early on about who will be served by a particular intervention.

As organizations consider populations and vocabulary that will be used to define populations and parameters, it is important to jointly consider intervention workflows such as screening questions, eligibility criteria, documentation, data sharing, and measurement. It is further recommended that metrics being used to evaluate the success of a social intervention revolve around something that can be measured and tied to the CBO activity. For example, an intervention serving individuals living with diabetes might measure processes, such as care plan adherence, attendance at education sessions, and number of engagements rather than a change to HbA1C levels. Breaking down complicated diagnosis codes and quality measures can reduce administrative burdens on CBOs and help maximize the partnership.

Access to Behavioral Health

Through CAMBA's participation in EngageWell, an independent practice association comprising behavioral health providers, CAMBA had a contract with Healthfirst's Health and Recovery Plan, which focuses on adults with significant behavioral health needs. CAMBA was responsible for comprehensive assessments, care plan development and submission, and other pre-intake activities for eligible clients. CAMBA received funding for these activities, however funding was contingent on reporting activities back to Healthfirst.

Section 5: Unresolved Challenges and Conclusion

Government is critical in bridging the divide between CBOs and MCOs to develop pathways to contracting. There are still unresolved challenges and recommendations that can be mitigated through policymaking and regulatory changes.

CBO Funding

CBOs are funded largely through government contracts, and due to inadequate funding, they experience a high risk of insolvency and financial distress. Improved funding would better equip CBOs to provide sustainable services and respond to public health crises such as COVID-19. Additionally, the State should develop more innovative funding streams, such as investments in initiatives that integrate health factors into government policymaking across all sectors such as education, housing, environment, urban planning, and transportation. However, in order to overcome the institutional barriers to cross-sector collaboration, this requires adequate investment by the State into these sectors.

As stated in HSC's [Integrating Health and Human Services: A Blueprint for Partnership and Action](#), the State should invest in CBO infrastructure or incentivize MCOs to invest in CBO infrastructure. This would allow CBOs to meet the operational requirements for hiring new staff, training, managing reporting and data, procuring technology infrastructure, and adhering to compliance activities, as funds to obtain these items are still lacking, which are all essential to managing an effective program.^{iv}

CBO Engagement in Policymaking

CBOs are well positioned to inform policies around the types of interventions that can be impactful and related payment for those interventions. The State should also engage CBOs in program design and identifying community needs so that CBOs can be better integrated into the health care delivery system and adequately paid for their services. This would ensure that communities are cared for and decrease the risk of failure of CBOs, which will have devastating consequences for New Yorkers.

Additional VBP Guidance and Requirements: Based on Collaborative discussions, some MCOs were unclear on how to structure contracts with CBOs, resulting in contracting delays or complete lack of contracting. The State should continue to provide guidance on successful contracting, and should consider incentivizing partnerships between CBOs and MCOs. As stated in our previous report, although VBP arrangements have encouraged both sectors to collaborate, more needs to be done to initiate learning for all stakeholders in order to develop shared goals and understand strengths and limitations, which would also promote better facilitation in the contracting process. This could be accomplished through expanding the current VBP requirements to include multiple interventions and providing better guidance to MCOs on what is allowable.

Conclusion: CBOs play a crucial role in addressing health-related social needs and many are prepared to engage in VBP arrangements that improve community health for all New Yorkers. As CBOs work to demonstrate the value of their services and their ability to deliver the intervention, MCOs should also come to the table as willing contracting partners to establish successful partnerships. These CBO and MCO collaboration stories show that the integration of health and human services is possible.

Glossary of Terms

Terms	Definitions
Allowable costs	Items or elements of an institution's costs that are reimbursable by a particular payer. For example, the Medicare program reimburses hospitals for certain costs (e.g., patient care activities, training physicians) and does not reimburse these organizations for certain other costs (e.g., research activities, lobbying). ^v
Benchmark	A level of care set as a goal to be attained. Internal benchmarks are derived from similar processes or services within an organization. Competitive benchmarks are comparisons with the best external competitors in the field. Generic benchmarks are drawn from the best performance of similar processes in other industries. ^{vi}
Beneficiary	An individual who receives benefits from or is covered by an insurance policy or other health care financing program. ^{vii}
Capitation	A method of payment for health services in which the provider is paid a fixed amount for each patient without regard to the actual number or nature of services provided. ^{viii}
Capitation rate	A fixed amount of money paid per person for covered services for a specific time; usually expressed in "per member per month" units. ^{ix}
Clinical performance measures	Instruments that estimate the extent to which a health care provider delivers clinical services that are appropriate for each patient's condition; provides them safely, competently, and in an appropriate time frame; and achieves desired outcomes in terms of those aspects of patient health and patient satisfaction that can be affected by clinical services. ^x
Direct costs	A cost that can be identified with a particular final cost objective, such as a contract. ^{xi}
Dual eligible	A person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid benefits. ^{xii}

Fee-for-service (FFS)	A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits. ^{xiii}
Health indicator	A characteristic of an individual, population, or environment which is subject to measurement (directly or indirectly) and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time). Health indicators may include measurements of illness or disease, positive aspects of health and of individuals' behaviors, and indicators which measure the social and economic conditions and the physical environment as it relates to health. ^{xiv}
Health Insurance Portability and Accountability Act (HIPAA)	The Federal law enacted to improve the portability and continuity of health insurance for groups and individuals, extend fraud and abuse measures to all types of insurers, and simplify administration by creating a framework for standardizing electronic data interchange in health care, including protecting the privacy and security of individually identifiable health information, often referred to as "protected health information." The privacy provisions specify that providers must give notice of their privacy policies and procedures to patients, obtain authorizations for use of the information, tell how information is generally shared, and how patients can access, inspect, copy, and amend their medical records.
Health Plan Employer Data Information Set (HEDIS)	A comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance. HEDIS Measures relate to many significant public health issues, such as cancer, heart disease, smoking, asthma, and diabetes. ^{xv}
Indirect costs	A cost for a common or joint purpose (e.g., accounting services) that cannot be readily identified with a particular final cost objective. ^{xvi}

International Classification of Diseases (ICD-10-CM)	A list of diagnoses and identifying codes used by physicians and other health care providers. The coding and terminology provide a uniform language that permits consistent communication on claim forms. ^{xvii}
Managed care	A health care delivery system organized to manage cost, utilization, and quality. ^{xviii} This is typically done through an insurance company which contracts with a network of specific health care providers and facilities and tries to manage costs through utilization management, service pre-authorizations, care management, and other activities.
Measures	Demonstrates how high-quality outcomes for beneficiaries are being achieved. They reflect core issues that are most vital to high quality care and better patient outcomes. ^{xix}
Medicaid Managed Care Organization (MCO)	An insurance plan for the delivery of Medicaid health benefits and additional services through contracted arrangements between State Medicaid agencies and an insurance companies that accept a set per member per month (capitation) payment for the delivery of these services.
Outcomes	A change in the health of an individual, group of people, or population that is attributable to an intervention of series of interventions. ^{xx}
Quality	For HCOs and MCOs the term “quality” refers to health care that is effective, efficient, equitable, safe, patient-centered, and timely. It is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Quality is measured using standardized data elements that have been selected by expert consensus. However, the measures alone do not always reveal the factors that account for differences in quality. Depending on their contracts, high quality scores for an HCO or MCO could result in additional or bonus payments.
Risk behavior	Specific forms of behavior which are proven to be associated with increased susceptibility to a specific disease or ill-health. ^{xxi}
Risk factor	Social, economic or biological status, behaviors or environments which are associated with or cause increased susceptibility to a specific disease, ill health, or injury. ^{xxii}
Utilization	The amount of health care services consumed by an individual or a population, which is influenced by factors that affect the need for care, the propensity to use services, and barriers to the use of services. Health care utilization can be appropriate or inappropriate, of high or low quality, expensive or inexpensive. ^{xxiii}

Endnotes

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