Developing Healthcare and Human Services Collaborations: Current Case Studies

Prepared by Health Resources in Action
in collaboration with Northeastern University

November 6, 2018

Authors: *Heather Nelson, PhD, MPH and Kristin Mikolowsky, MSc, Health Resources in Action in collaboration with Jean McGuire, PhD, MSPH and Kim Shellenberger, MBA, Northeastern University*

Health Resources in Action
Advancing Public Health and Medical Research

Northeastern

Introduction

The healthcare industry's collaboration with the human services sector is growing. Multiple factors, including expanding integrated healthcare and financing options and value-based performance strategies, have contributed to healthcare's recent increasing engagement with and financing of human services. The human services sector brings significant expertise to healthcare because it addresses the social determinants of health (SDOH), has access to and understanding of diverse and vulnerable populations, and possesses deep experience supporting service delivery, navigation, and resource coordination. However, unlike healthcare, the human services sector primarily depends on discretionary government grants and philanthropic funds; thus, the human services sector has experienced considerable financial insecurity.

Promising models for collaboration between the healthcare and human services sectors have evolved in hospital and healthcare systems across the country and in accountable health communities and other community-wide initiatives. State and federal efforts have also contributed to shaping these alignments. However, the human services sector's involvement in healthcare-related contractual and reimbursement mechanisms is still new. With funding from the Robert Wood Johnson Foundation, Health Resources in Action (HRiA), in collaboration with Northeastern University, developed three case studies to better understand the organizational and financial relationships between the involved healthcare entities and human services organizations and to identify related challenges and opportunities.

Methods and Structure

An environmental scan of peer-reviewed literature, as well as white and gray resources, was initially conducted to better understand the current landscape of healthcare dollars financing human services. Results from the scan were used to construct interview questions to guide case study development and to identify potential case study sites. Potential case study sites identified through the literature were then discussed with experts working in the field, and through iterative discussions and further exploration of the literature. Three case study sites were selected. In each, the state's healthcare financing and delivery transformation efforts are resulting in healthcare and human services collaboration.

For each case study, HRiA and Northeastern gathered relevant literature on the study site and information about the state and local healthcare and social services financing context, and then conducted telephone interviews using a semi-structured interview guide. Interviewees were identified through the literature and recommendations from interviewees and others working in the field. Across the case study sites, 22 interviews, lasting approximately 60 minutes each, were conducted with 26 individuals. Interview notes were coded and reviewed by team members to identify the key themes that are presented in these case studies.

The cases are presented in an order that illustrates the spectrum of state involvement within healthcare transformation models mandating collaboration between the healthcare and human services sectors. We begin with an examination of one of Oregon's Coordinated Care Organizations, Health Share of Oregon, where expenditures for human services activities are permitted but not required. The Oregon case study is followed by one describing the new Prevention Services Initiative in Connecticut, which requires the execution of contracts for non-medical services and supports between participating healthcare and community-based organizations. Such contracts are required after a period of third party technical assistance promoting relationship-building and contract negotiation between the two sectors. The final case study focuses on the Massachusetts Accountable Care Organization (ACO) and Community Partner model that requires all new Medicaid ACO's in the state to work with designated behavioral health and long-term services and supports providers for community-based care coordination.

Case Study Key Themes

The states highlighted in the case studies have developed different structures and opportunities to facilitate the alignment of healthcare and human services. However, across the case studies, the following common key themes emerged:

- **Transformation demonstrations in Medicaid healthcare delivery and healthcare financing can support state efforts to coordinate healthcare and human services.** States have the potential to play critical roles in facilitating coordination and alignment across the healthcare and human services sectors. Although the states discussed in the case studies are at different stages of healthcare transformation, their innovative efforts to align healthcare dollars and human services are all built upon some level of transformation. Healthcare transformation is necessary to support the long-term sustainability of healthcare-human services collaboration.

- **Whenever possible, healthcare should seek to first *buy* versus *build* needed human services.** Generally, in the case studies, both healthcare and human services providers indicated that it makes sense for healthcare to *buy* existing humans services before developing internal capacity to address the social needs of their patients. Given their experience, expertise and mission, human services providers are already well-positioned to address the SDOH, particularly among vulnerable and hard-to-reach populations.

- **Government entities are an important provider of human services.** In Oregon and Connecticut, as in many states, healthcare organizations are working with local government entities, including local and county health departments, to provide social services to their members. Understanding the potential contributions and challenges of human service delivery through both the government and non-profit sectors will foster the development of effective approaches to addressing the SDOH.

- **Human services providers need fiscal, administrative, IT and other infrastructure development to build effective collaborations with healthcare.** Human services providers have been historically under-funded and need infrastructure funding before entering into financial and/or contractual relationships with healthcare entities. Specific areas for capacity building include IT and analytic support. Without this type of support, it is challenging for human services providers to effectively address the expectations of healthcare entities such as providing case management information or performance metrics.

- **Technical assistance can benefit both healthcare and human services providers in building relationships and collaborative efforts.** Overcoming cultural, resource, power and other differences between the healthcare and human services sectors is challenging. When human service entities that are accustomed to receiving their funding through discretionary government grants and philanthropic funds are asked to enter into unfamiliar contracts and payment mechanism with healthcare entities, the power differential between the two sectors is highlighted. Human services providers need technical assistance (TA) and support in building business cases to set pricing, determine service mix, and *sell* services to healthcare. Healthcare providers can benefit from TA and education about the evidence for and quality and value of human services providers' work to address the social needs of their patients. In addition to providing TA to these two sectors separately, efforts to convene the sectors and establish trusting relationships can advance new models of collaboration.

- **Addressing social determinants of health takes time and success is difficult to attribute to single interventions, making it challenging to demonstrate a return on investment to healthcare.** Human services providers are well-positioned to reach vulnerable populations and high healthcare utilizers, but work to address SDOH is complicated, time-intensive, and can require long time horizons in order show change. Other barriers to demonstrating return on investment (ROI) include member "churn" (i.e., turnover when enrollees transition between different types of health insurance coverage and/or uninsurance), which complicates tracking benefits to plan-specific members, as well as methodological challenges related to attributing avoidable outcomes and costs to the human services delivered.

- **Currently, human services providers are rarely paid using performance-based arrangements.** Human services providers are generally hesitant to engage in reimbursement methods that are based on the achievement of outcome measures (i.e., either a payment or bonus for achieving outcomes or withheld payments if outcomes are not achieved). Human services providers face several barriers related to payment based upon performance, including insufficient client volume and the long time horizon necessary to see the benefits of addressing SDOH. Healthcare itself is not prepared to offer value-based purchasing to human service providers. Ensuring that human services providers are able to track and evaluate their outcomes is, in general, of interest to both sectors. However, the impact of incorporating upside (i.e., uncertain financial gains) or downside (i.e., lower than expected returns) risks into the payment structure has not been widely explored.

- **Identifying reliable funding for increased human services utilization is a challenge. V**alue-based payment models have the potential to incentivize healthcare stakeholders to engage social service providers in addressing the social needs of their patients. However, healthcare entities are still relying on inconsistent funding streams (e.g., community benefits dollars and administrative and philanthropic grants) to fund initiatives that address the social needs of their members. Models for funding such healthcare and human services collaboration would benefit from further development. Flexible service dollars in Oregon and Massachusetts promise a consistent funding source for human services. However, in both cases, confusion remains about how these dollars can be spent.

Case Study: Health Share of Oregon

This case study of Health Share of Oregon provides examples of healthcare and human service collaboration in one of Oregon's fifteen Coordinated Care Organizations (CCOs) and discusses lessons learned from these partnerships. For this case study, ten interviews were conducted with twelve individuals representing Health Share of Oregon staff, Health Share of Oregon managed care plans, local government and non-profit agencies, and the Oregon Health Authority.

Model Overview

Background and State Context: Oregon Coordinated Care Organizations

Since 2012, Oregon Health Plan (the state's Medicaid program) members have received their physical, mental, and dental care through CCOs located across the state. Oregon's CCO model was approved in 2012 through a five-year 1115 Medicaid demonstration waiver, which has been renewed for 2017-2022. The CCOs aim to reduce the state's rate of growth in per-capita Medicaid spending.

Currently in Oregon there are 15 CCOs serving approximately 800,000 Medicaid members within defined geographic regions. The Oregon Health Authority (the state Medicaid agency) provides each CCO with a global budget that is based on a per member per month (PMPM) capitated amount for integrated physical, mental, and dental healthcare delivered through a partnership of providers and plans. CCO structures across the state vary, but generally, CCOs are held accountable for both cost and quality. They bear upside and downside risk for costs for their assigned members (e.g., CCOs are rewarded with any savings and are responsible for any losses).[1] CCOs are responsible for meeting 17 quality incentive metrics. Failure to do so results in financial losses. However, they are also eligible for a quality bonus if they achieve the desired targets; the state withholds four percent annually for this purpose. Although CCOs must demonstrate that they are paying providers based on value versus volume, the CCOs can choose which types of alternative payment methods to implement.[2]

Mechanisms for Collaboration between Coordinated Care Organizations and Community and Human Service Stakeholders

While the state of Oregon did not mandate that CCOs partner with human services providers, some incentives for collaboration exist:

Within their global budget, CCOs have the ability to offer two types of **health-related services**:[3]

1. **Flexible services**, which are cost-effective services offered to an individual member to supplement covered benefits, and
2. **Community benefit initiatives**, which are community-level interventions that include members, but are not necessarily limited to members only, and are focused on improving population health and healthcare quality.

Oregon's recently renewed Medicaid 1115 waiver clarified expectations related to expenditures for health-related services: Health-related services that meet specified definitions are included as medical expenditures (not administrative expenditures) in CCOs' medical loss ratio (MLR). MLR is a financial measurement that describes the percentage of funds that is used to pay medical claims and related quality of care improvement activities. Inclusion of health-related services in the numerator of the MLR helps CCOs meet the state's MLR standard of 85 percent.[3] Examples of activities that can be covered as health-related services by CCOs include care coordination or navigation, self-management education, home and living environment items or improvements (e.g., air conditioners), housing supports

(e.g., utilities), and community or public health programs (e.g., farmer's markets).

In addition to the option of offering health-related services, CCOs are required to complete a community health assessment and community health improvement plan and are required to have a community advisory council (CAC) comprised of at least 51% Oregon Health Plan consumers. The CACs oversee the community health assessment process, adopt the community health improvement plan, and publish an annual report on the progress of the plan.

Health Share of Oregon: Description and Population of Focus

Health Share of Oregon is the largest CCO in the state and serves more than 240,000 Medicaid members in the Portland Metropolitan Area. While many CCOs in Oregon are administered through managed care plans that existed prior to the development of CCOs, Health Share of Oregon chose to establish a new nonprofit entity that is an "umbrella" or "backbone" organization with its own staff that administers the CCO.[1] The umbrella organization retains two-percent of the CCO's global budget from the Oregon Health Authority, which is used for operations, administration, convening, coordination, community engagement, strategic investments, and transformation efforts aimed at high-utilizers. The rest of the funding is apportioned to the risk-accepting physical, behavioral, and dental health managed care plans which then pay providers directly.[4] Alternative payment approaches within each managed care plan are still evolving; some providers are still paid on a fee-for-service basis. A list of Health Share of Oregon's participating plans is shown in the Figure below.[5]

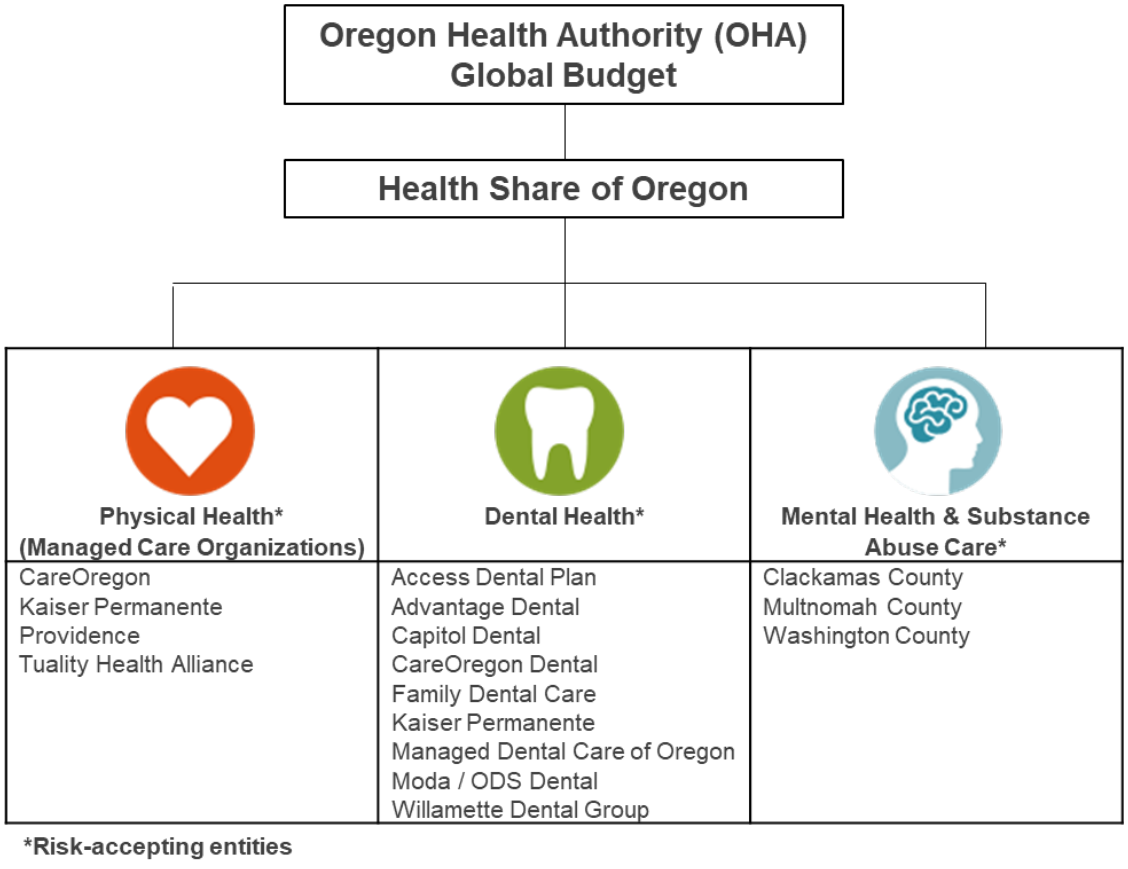


Figure Source: Health Share of Oregon. Retrieved from http://www.healthshareoregon.org/for-members/my-health-plans.html

Model Development and Structure

Facilitating Environment

The Oregon Health Authority allowed, but did not require, Coordinated Care Organizations and Managed Care Organizations to contract with human services providers.

Due to the regional organization of the CCOs and because the Oregon Health Authority does not require CCOs to contract with human services providers, the CCOs are able to establish relationships with local human services providers and take their local context into account. Many interviewees noted that such flexibility was essential given the regional differences in types of agencies and in history and approaches for working together. In general, some degree of flexibility was seen as important for building successful partnerships. However, some interviewees expressed frustration with the lack of requirements around how CCOs should work with human services providers to address SDOH. For example, one interviewee noted that "…*having 16 different CCOs meant 16 different types of ways to invest in SDOH with no real statutory guidance*." These interviewees indicated that it would be helpful for the Oregon Health Authority to provide more oversight of and guidance (i.e., about how to address the SDOH) to the CCOs that have less experience in partnering. They further suggested that the Oregon Health Authority establish requirements for a minimum level of collaboration.

Funding for human services providers is available through health-related service dollars but clearer guidance is needed.

CCOs have *health-related service funds* that can be spent on *flexible services* and *community benefit initiatives*. Although promising for addressing SDOH, confusion remains about how the dollars can be spent. *Flexible service dollars* can be used to provide case-by-case support, such as care coordination or self-management education to individual members. Case-by-case support must be documented and approved by a health plan case manager. *Health-related service dollars* can also be used for *community benefit.* Such spending does not need to be linked to individual members. For example, one interviewee discussed using health-related service funds to pay for building a park or a food pantry. Some CCOs and CCO partners are unaware that health-related service dollars can be included in the medical loss ratio (MLR) and remain unsure of whether such spending is attributable to medical spending or administrative costs. While Health Share and the Oregon Health Authority's Transformation Center provide TA and information on this issue, interviewees noted that greater clarity about the use of *health-related service dollars* could facilitate increased or more targeted use of these funds.

Human services providers encompass community-based non-profit organizations and government agencies.

Many interviewees noted that local human services are provided by both government agencies and non-profit entities. As one interviewee explained, "*We [Health Share] operate in two realms. One is social services like governmental social services like corrections, foster care, [and the] public health division. And then there are community-based supports around housing, food, etc*." Multnomah County Tri-County Service Coordination Program (see below), a publicly-run program and key partner of Health Share, once considered leaving the county government to form a non-profit to deliver their services. Ultimately, they decided to remain a public program to retain access to public employee benefits that support staff retention. Interviewees noted that CCOs' flexibility to work with government agencies and non-profits alike is a strength.

Health Share's Role in and Approach to Working with Human Services Providers

Human services providers have been at the table since the formation of Health Share of Oregon.

When discussing the intersection of healthcare and human services within the context of Oregon's CCOs, interview participants noted that human services providers have been part of the conversation since the formation of Health Share of Oregon. Currently, as CCO CAC members, human services providers are involved in overseeing the development of the CCO's state-required community health assessment and community health improvement plan. Human services providers were doing work to address the SDOH long before the CCOs were formed. In fact, in many cases, the work that is currently underway to address social needs is a continuation of work and investments (from a variety of sources, including federal grants and community benefit funds) that had been happening prior to the existence of Health Share of Oregon.

There is recognition of historic under-investment in human services providers and the power differential between human services providers and healthcare stakeholders.

All interview participants talked about the human services sector's historic challenge with securing consistent resources necessary for sustainability. Given this under-investment and ongoing need for funding sources for human services, interviewees noted that a *power differential* exists between the healthcare and human services sectors. CCO and Managed Care Organization (MCO) representatives discussed the importance, when developing funding relationships with human services providers, of maintaining a sense of humility and recognizing the value of human services providers' work. As one participant said, "*There's recognition that healthcare is arriving to the party late… people have been doing this [working on SDOH] for years in Community-Based Organizations [CBOs]. We are showing up with the pocketbook, but we have to show up with some humility and give up some power and authority. Say 'we're here, we're late, I'm sorry, we have resources, what's the best way for us to work with you?'*"

Health Share is a convener, influencer, and technical assistance provider working in a transformation space.

As the backbone organization, Health Share uses its administrative dollars to fund and support innovation and transformation. Within the CCO, it is more often the risk-accepting MCOs, not Health Share, that work directly with human services providers to bring services to their members and communities. As a result, some human services providers have individual relationships with the MCOs within the CCO in addition to working directly with the Health Share umbrella entity. As one participant discussed, "*The fun part is we [as Health Share] can think about transformation; the drag part is that we don't control money. We keep a small percentage for our operations, but decisions about flexible services and money are made by our health plan partners*."

Health Share is a Strategic Partner rather than a long-term funder of human services providers.

Health Share's relationship with the human services sector is to provide initial investments, including staff time for TA and, in some cases, limited short-term funding for infrastructure development. The relationship also ensures that the CCO MCOs "buy in" to the programs and services, and that infrastructure is being developed in such a way that, eventually, these social services can be purchased directly by the MCOs. In many cases, Health Share has supported human services providers to build business cases and relationships with payers. As one interviewee noted, "*We don't view ourselves as a long-term funder… [We made a big] investment in [a local community health worker association], but we won't be the purchaser of this service going forward… which is why it's so important to have buy-in from health plans so services can be billed after [they] show outcomes*." For example, as described in the success stories presented below of human services providers working with Health Share, Health Share currently provides infrastructure funding to Project Access NOW and previously provided TC911 with TA and support in building their business case, determining pricing and service mix, and calculating ROI.

Success Stories: Examples of Health Share's Collaboration with Human Services

Tri-County Service Coordination Program (TC911)

Program Services and Population Served: The Tri-County Service Coordination Program, or TC911, identifies frequent 911 callers through an analysis of monthly data from ambulance companies and direct referrals from ambulance and fire first responders in the region. Six licensed clinical social workers and one Peer Support Specialist reach out to the identified frequent callers regardless of payer to connect them with care and services to address unmet needs and reduce unnecessary emergency healthcare utilization. The program is administered and operated through the Multnomah County Health Department's Emergency Medical Services (EMS) Office. Roughly 89% of the approximately 500 unique people served by the program per year are Medicaid enrollees. The program also provides case management services and linkages to non-emergency care, such as mental health programs, primary care clinics, long-term care supports, and other social services, including housing and food security resources.

Program History: In 2008, a pilot study showed a decrease in EMS utilization among high-utilizers who were connected with social work and care coordination support. In 2012, following the pilot study, the program became part of a three-year, regional Centers for Medicare and Medicaid Innovation (CMMI) grant. TC911 also received one-time funds from Providence Health System's Community Benefits program to serve non-Medicaid members. Results from the CMMI grant showed statistically significant reductions in EMS and Emergency Department (ED) utilization among Medicaid patients, and a reduction of approximately $900 per person per month or $10,000 savings per person per year.[6] In the third year of this CMMI grant, TC911 worked with Health Share of Oregon to develop and present a business case, calculating return on payer investment and a case rate (just under $3,000 to serve each person per year), and to project the number of people that could be served annually. Ultimately, the information was compelling enough for Health Share of Oregon to continue contracting with TC911.

Funding and Relationship with Health Share: Currently, 83% of TC911's $1.194 million in funding comes from Health Share's administrative line item; the remainder is subsidized by Multnomah County general funds. TC911 has a three-year services contract with Health Share of Oregon to serve 350 high-risk, high cost Health Share of Oregon (Medicaid) member clients annually, allowing for a 3% increase each year. The contract aligns with the business case developed by TC911 (described above), pays for direct service staff and associated costs, and includes patient support funds (calculated at $50 per person/year to assist with basic needs). TC911 submits expense reports monthly to Health Share and has other monthly progress reporting requirements. For example, TC911 tracks the number of people referred, number served, demographics, type and number of encounters, and insurance type. Due to TC911's rigorous and successful evaluation history, payment from Health Share is no longer contractually tied to clinical outcomes. Originally, TC911 attempted to contract separately with individual Health Share payers, but it was ultimately determined that funding should flow from Health Share's administrative line item as TC911 was viewed as a regional resource serving the collective CCO membership.

Project Access NOW: Regional Community Health Network

Program Services and Population Served: Project Access NOW is a community health non-profit "network supporter" that creates opportunities and structure for community-based navigation. One of Project Access NOW's key programs is the Regional Community Health Network (RCHN) that aims to serve individuals and families in a tri-county region. Within the RCHN, the Community Pathways Network matches patients with a Navigator who can connect the patient and their family to a variety of direct services in their community and facilitate access to healthcare services and supports (see Figure). Modeled after the Pathways Community HUB model[i], the Community Pathways Network is built on an existing network of social services providers and serves a diverse population by coordinating services among different types of community service providers.

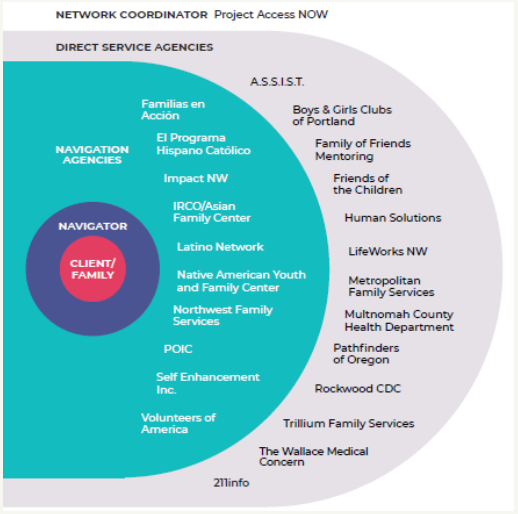


Figure created by Project Access NOW

Program History: Project Access NOW was originally created to coordinate donated care for the uninsured. Following the passage of the Affordable Care Act and the formation of Oregon's CCOs, Project Access NOW identified the need for continued services for the uninsured and recognized the opportunity to create an infrastructure to support access to healthcare and related services for the broader community. Project Access NOW developed the RCHN to, among other things, coordinate a network of community-based organizations that provide services to address the SDOH.

Funding and Relationship with Health Share: Originally, Project Access NOW received philanthropic funding for RCHN's development and innovations. Project Access NOW began having conversations with Health Share about their work early in the CCO's formation. Currently, Project Access NOW receives funding from Health Share for the RCHN's infrastructure. Project Access NOW is also in the process of working with Health Share's MCOs to establish commitments for MCOs to pay to make referrals to "Pathways" within RCHN's Community Pathways Network. RCHN is set up to allow for multiple investors and allows MCOs access to an entire network of diverse services, sparing the MCO from having to set up individual relationships with many community-based service providers. The RCHN Community Pathways Network has 37 "Pathways" and each corresponds to a SDOH indicator (e.g., housing needs) and has a dollar value and defined outcomes for success (e.g., moving into and maintaining affordable and safe housing for six consecutive months). Project Access NOW worked with the agencies in the RCHN to adapt the national pathways model for their local context and develop the dollar values.

[i] Agency for Healthcare Research and Quality. (2016). *Pathways Community Hub Manual*. Rockville, MD. Retrieved from: https://innovations.ahrq.gov/sites/default/files/Guides/CommunityHubManual.pdf

Opportunities and Challenges

Government entities are important providers of human services.

In the Oregon CCO model, local government agencies, such as county health departments, play an important role in delivering social services to Medicaid members. Across the country, human services are provided by a range of entities including local and state government and non-profit and for-profit organizations. Understanding the potential contributions and challenges of human service delivery through each sector will foster the development of effective approaches to addressing the SDOH.

Human services providers need infrastructure support.

Human services providers have been historically underfunded, lack infrastructure, and need funding for capacity building before entering into contracts with MCOs. Without this type of support, it is challenging for human services providers to effectively address the expectations of healthcare entities such as providing case management information or performance metrics. One interviewee commented that, "*As I think about where RWJF makes investments, I do think that there needs to be recognition that most health systems are used to investing in a space with a totally different infrastructure [than human services provider infrastructure].*" Developing new partnerships and services require new funding.

Human services providers need sustainable funding.

As described above, human services providers have historically lacked consistent funding sources and have relied on project-specific funding (for example, community benefit funding or other grants) to sustain their operations. As one interviewee noted, "*community benefit does some of the 'here's some money go do good' still… [we] hear from CBOs that 'last year you cared about school absenteeism, now it's trauma, it's hard to deal with one year of funding for [a] small focus."* To support sustainability, community benefit dollars must be braided with or replaced by other funding sources. In particular, participants noted that healthcare funds, for example operational funds, should be used to purchase services from human services providers. One interviewee stated, "*I don't want to minimize community benefit. But when we broadly talk about how we can move health resources upstream to address social determinants of health, we're talking about how we can move the money that right now we're using to support medical or healthcare services.*"

Human services providers are rarely paid based on achievement of outcome measures.

While human services providers may be paid to serve a certain number of individuals or health system members, interviewees noted that they are rarely paid based on the achievement of outcome measures. Generally, both sectors are interested in having human services providers track and evaluate their outcomes; however, the concept of incorporating upside or downside risk into payment structures has not been something widely explored or stated as a goal. In the words of one interviewee, *"[we] haven't gotten into [the] risk space*." One barrier to payment based on outcomes is the long time horizon required to see benefits of human services providers' work. Other barriers include not yet having enough client volume to take on risk, and healthcare itself not being prepared to provide payment based on outcomes.

Addressing social determinants of health takes time.

Work to address SDOH is complicated and it requires a long time horizon in order to demonstrate change. According to one participant, "*It's really complicated. They [Health Share] need to be in it for the long haul. This isn't like a two-year thing. We need to be in it for at least five years*." In particular, interviewees attributed the challenges in quantifying ROI not only to the length of time necessary to show change, but also to member churn that makes tracking the benefits of discrete human services to plan-specific members difficult.

When addressing the social determinants of health, whenever possible, healthcare should seek to first *buy* versus *build* needed human services.

Participants unanimously felt that it is better for healthcare to *buy* rather than *build* services to address the SDOH. They discussed discomfort with the idea of healthcare *building* human services because they lack the expertise and experience to effectively deliver these services. One interviewee from the human services sector noted that her organization had been "*doing this work much longer and before Health Share*," and stated that, "*I don't think Health Share is in a position to do the community-based work*." While healthcare stakeholders may agree with this view in theory, a few interviewees noted that it can be hard "in practice" for healthcare entities not to *build* services because it goes *"against every grain in their body not to just build their own solution within their own systems*." Some interviewees went so far as to say that funding for human services ideally would not flow through healthcare at all. For example, one stakeholder questioned, "*Why does a health plan get to decide what housing to pay for? That is not our forte! [We] should refund dollars to public health authorities…I think we're medicalizing social problems*." Although the preference for *buying* over *building* was unanimous among the Health Share stakeholders interviewed, the preference may be a function of Health Share's unique context where many human services providers in the area were established and well-respected prior to the formation of the CCOs.

Having a hub or network can facilitate relationship-building for both healthcare entities and human services providers.

Given the complex network of healthcare providers and payers, interviewees were clear that both human service and healthcare plans/providers appreciate having the coordinating function of the CCO for relationship building, TA, and support. This coordination support has helped with service development and pricing and created pathways for contracting discussions between human services providers and the MCOs. Respondents from both sectors are concerned about how best to establish contractual relationships, especially where there are multiple human services of interest and multiple MCOs and other provider entities that may want to purchase their services. As one person mentioned, "…*for a health system to contract with 12 CBOs, that is not realistic and not a great bang for their buck*." Similarly, human services providers noted that it can be daunting to develop contractual relationships with multiple health systems. As one interviewee stated, developing "*separate contracts with each health entity – [that] would be crazy*."

Case Study: Connecticut's Prevention Services Initiative

The Prevention Services Initiative is part of the State Innovation Model (SIM) population health plan and offers incentives and structures to encourage healthcare entities to work with community-based organizations (CBOs), including non-profit organizations and local health departments. For this case study, six interviews were conducted with eight individuals representing CBOs, local public health departments, healthcare entities, and Connecticut state agencies and offices.

Model Overview

Background and State Context

In 2014, Connecticut was awarded a State Innovation Model Round 2 Test Design award of up to $45 million through September 2019. Connecticut's State Healthcare Innovation Plan, created under the SIM grant award, has three primary components to its healthcare delivery system transformation: (1) Person-Centered Medical Home Plus (PCMH+); (2) A Community and Clinical Integration Program (CCIP); and (3) The Advanced Medical Homes Glide Path (AMH).[7] The Connecticut Department of Social Services (DSS) is the state agency primarily responsible for administering HUSKY, the state's Medicaid program. Under the PCMH+ shared savings program, DSS funds Federally Qualified Health Centers (FQHCs) and Advanced Networks (ANs)[ii] to provide Enhanced Care Coordination Activities for approximately 180,000 of its 800,000 Medicaid members[iii]. PCMH+ is an upside-only shared savings initiative through which participating FQHC and AN entities receive a portion of any savings achieved if benchmarks on identified quality measures are met.[8] Through CCIP, entities participating in PCMH+ may receive targeted TA to enhance their organizational capabilities related to three core standards: comprehensive care management, health equity interventions, and behavioral health integration. Under CCIP, Community Health Collaboratives will also bring together clinical and community stakeholders to develop consensus protocols for coordinated care and community linkages. Entities that commit to meeting CCIP standards will be eligible to receive monetary transformation awards.[9]

In addition to the delivery system transformation plan, Connecticut outlined a plan for improving population health in its SIM award. One of the core efforts under this plan is the Prevention Service Initiative (PSI), a "linkage model that strengthens the relationships between CBOs and Advanced Networks/Federally Qualified Health Centers (AN/FQHC)."[8] **The PSI is the focus of this case study and is described further below**.

[ii] Advanced Networks are independent practice associations, large medical groups, clinically integrated networks, and integrated delivery system organizations that have entered into shared savings plan (SSP) arrangements with at least one payer; many Advanced Networks include one or more anchor hospital; for more information, see: http://www.healthreform.ct.gov/ohri/lib/ohri/sim/test_grant_documents/application/ct_sim_test_program_narrative_final.pdf

[iii] As reported by Connecticut Department of Social Services; for more information, see: https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Health-and-Home-Care/PCMH-Plus/Wave-2/PCMHplus-Update-for-May-2018-SIM-Steering-Committee-51018.pdf?la=en

The Prevention Services Initiative: Description and Population of Focus

The Prevention Services Initiative provides incentives and structures to encourage healthcare entities to work with CBOs, including local health departments. PSI was designed to address the increasing interest among healthcare institutions that receive value-based payments in partnering with CBOs to maintain member health and control costs. However, perceived barriers in the areas of contracting, data sharing, and outcomes measurement threatened the development of these healthcare-CBO partnerships. Additionally, healthcare stakeholders wanted assurance that the CBOs with whom they would hold contracts would have the capability to deliver high-quality services. The community-based stakeholders, on the other hand, expressed the need for a "translator" to clarify healthcare terminology and to support them in contract negotiations with healthcare entities. The PSI aims to address these barriers and needs.

The goals of the PSI are to:[12]

1. Increase the number of individuals with unmet prevention needs who complete community-placed, evidence-based prevention services and maintain or improve wellness.
2. Improve healthcare organizations' performance on quality measures related to asthma or diabetes and associated Emergency Department utilization or admissions/readmissions for an attributed population through use of community-placed, evidence-based prevention services.
3. Enhance business competency skills and organizational capabilities of CBOs so that they can enter into at least one contractual relationship with a healthcare provider that is participating in value-based payment.

While the PSI builds upon and expands existing work that is happening nationally and in Connecticut (including the PCMH+ and CCIP initiatives[13]), the PSI is unique in that its ultimate purpose is for payment to flow from healthcare to community-based entities. The Connecticut SIM leadership, in designing the PSI model, intentionally incorporated this focus on payment with the goal of developing sustainable relationships. Ultimately, SIM's vision is that healthcare organizations will fund the ongoing provision of the PSI priority services.

In early 2018, healthcare organizations and CBOs were invited to respond to a PSI Request for Applications. To be eligible to participate, healthcare organizations had to be ANs or FQHCs. Preference was given to PSI applicants who were part of the Medicaid PCMH+ and CCIP programs described above. Healthcare organizations also had to be participating in accountable arrangements (Medicaid PCMH+, Medicare Shared Savings Program, and/or commercial payers' shared savings programs) with at least 500 members living in one of the three target communities: Bridgeport, New Haven, and Middletown. CBOs, including local health departments, were eligible to apply if they had the capacity to provide services in at least one of the three the target communities, and if they currently provided at least one of the following priority services: a chronic disease self-management program with a focus on diabetes self-management or asthma self-management and home environmental remediation. Asthma and diabetes services were chosen as the focus to test the PSI model because they are evidence-based, offer potential healthcare savings, and also have the potential to improve some quality of care measures.

In June 2018, seven CBOs (four local health departments and three non-profit human services providers) and seven healthcare organizations were selected to participate in the PSI model. All participating organizations are expected to commit to all requirements of the PSI, including executing at least one financial contractual arrangement with another healthcare or CBO organization participating in the PSI. The state will subsidize this financial contract for the first 12 months, after which it is expected that the

healthcare entity will cover the costs of the contract (more information below). Participating entities may choose to focus their community-clinical collaborations on subgroups of patients or members (e.g., high cost/high need patients).

Mechanisms for Collaboration between CBOs and Healthcare Organizations

Technical Assistance

Both the selected healthcare organizations and CBOs in this Connecticut model will receive 18 months of no-cost TA from a SIM PSI TA consultant, Health Management Associates (also procured in 2018). The CBO TA component of the model aims to build the capacity of CBOs, who may traditionally have been grant-funded, and to facilitate the development of formal, contractual relationships, with specific financing mechanisms, between CBOs and healthcare entities. Specifically, this TA will help CBOs develop business plans that include performance metrics and service pricing, processes to accept referrals of patients from healthcare, and processes to assess the impact of their work on health outcomes and ROI. The healthcare TA component of the model will support providers in identifying unmet needs of their patients and developing systems for referring to, communicating with, and monitoring of CBOs. As shown in the figure below, the TA provider will also bring together the CBOs and the healthcare organizations to establish partnerships and begin negotiating contracts in which healthcare organizations pay CBOs for services provided to patients. The state does not specify the volume of patients or clients to be served, any sub-populations that must be served, or pricing of CBO services; these details will be determined through the TA-facilitated contract negotiations.

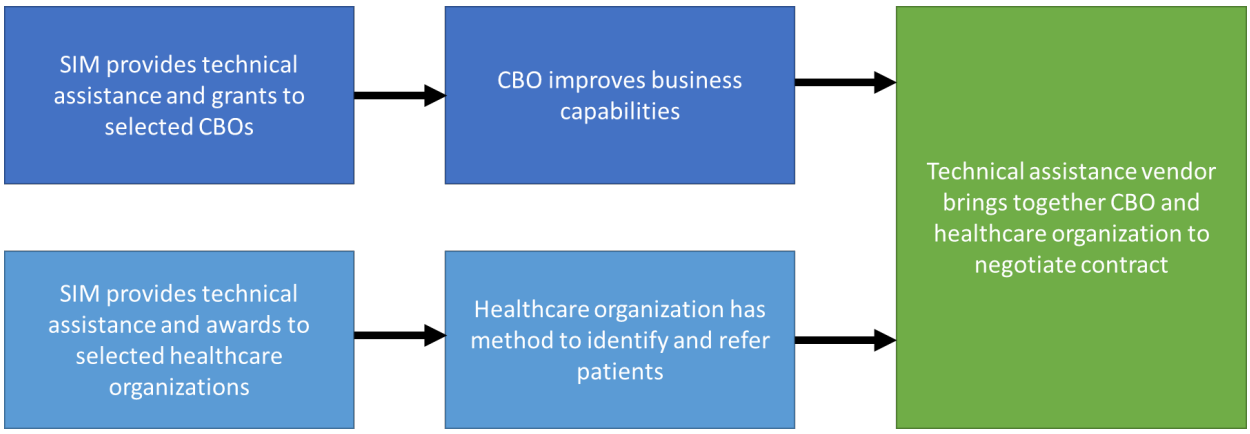


Figure Source: State of Connecticut Office of the Healthcare Advocate, State Innovation Model Program Management Office. (2018). Request for Applications (RFA) for Prevention Service Initiative for Healthcare Organizations. Retrieved 7/2/18 from https://biznet.ct.gov/SCP_Search/BidDetail.aspx?CID=45353

Funding

Up to $50,000 is available to each CBO over the 18-month period of performance. The initial awards, made in June 2018, provide up to $20,000 to cover staff costs and other expenses related to participation in the TA activities and related PSI work (e.g., time spent developing the business plans). After three months of receiving TA, CBOs will be eligible to apply for an additional $30,000 of funding if they have completed a Prevention Service Business Plan. Up to $100,000 is available to each healthcare organization to fund the development of a financial contractual arrangement (utilizing any payment model) with up to two CBOs, as well as operational investments (e.g., in health information technology). For the financial contractual arrangements with CBOs, healthcare organizations may use the funds to cover 80% of the cost of the first six months and 60% of the costs of the second six months. The expectation following these first 12 months is that, based on an ROI analysis, the healthcare organization would cover 100% of the contract after the first year.

Prevention Services Initiative Development and Structure

The Prevention Services Initiative requires the development of a financial relationship between healthcare and community-based entities, but allows for flexibility in structure.

In the early stages of the development of the PSI, Connecticut's SIM leadership did not anticipate requiring funding to flow from healthcare to community organizations. However, after reviewing existing models in other states, Connecticut leaders concluded that "*when you have money attached, and outcomes… the stakes are higher, you really move how the care is delivered*." Thus, in planning for the PSI model to promote clinical-community linkages, Connecticut leaders noted that they "*couldn't ignore the financial [pieces]*" because "*there's no other way to make it sustainable*." The PSI requires that healthcare and community-based entities enter into negotiations to develop contractual relationships that include payment mechanisms for CBO-provided services. However, what these arrangements look like in practice will be determined through the negotiations. In other words, as one interviewee stated, "*whether [they] want to do a per member per month, or just pay monthly. That's going to be up to them*." This flexibility and the voluntary nature of the negotiations is also intended to build buy-in and create feasible contracts, thus supporting sustainable outcomes. Lastly, it was noted that value-based payment models incentivize the healthcare sector to consider developing relationships with CBOs. As one interviewee explained, *"[without] value-based payment, PSI wouldn't make sense, [healthcare] wouldn't have [a] business interest and [it] wouldn't be sustainable*."

The Prevention Services Initiative recognizes the importance of providing technical assistance to both community-based organizations and healthcare entities.

The PSI model provides individual TA to both healthcare entities and CBOs, as well as joint sessions that promote relationship-building and contract negotiations. The TA primarily focuses on the CBOs. One interviewee described the CBO TA as "*a mini-MBA*" that will support CBOs in marketing and monetizing their services, analyzing demand and capacity, and ultimately developing contracts where healthcare entities *buy* their services. While the need for this type of CBO TA was widely recognized as vital, some stakeholders also noted the importance of TA for the healthcare grantees. In particular, interviewees noted that the healthcare sector will benefit from education about the evidence and value of CBOs' work, particularly around the SDOH. As one interviewee noted, "*I like that [there is] TA training on both sides. There is science to what [CBOs] do*."

The focus on asthma and diabetes in the Prevention Services Initiative is a concern for some stakeholders.

The PSI solicitation specified that, to be eligible to participate in the PSI, CBOs must provide services focused on asthma or diabetes chronic disease self-management programs. Asthma and diabetes services were chosen as the focus because they are evidence-based, offer potential ROI, and also have the potential to improve some quality metrics. However, some stakeholders expressed concern or confusion about narrowly restricting the PSI to these types of programs and services. Some interviewees noted that healthcare entities often have programs and services focused on asthma and diabetes internally, and therefore the idea of seeking external support for these issues is not intuitive and is potentially duplicative. As a potential solution to incentivize collaboration, some interviewees suggested that healthcare entities look to CBOs to work with their highest utilizers to address the SDOH in addition

to or instead of offering chronic disease self-management. As one interviewee described, "*It takes more than chronic disease self-management programs [to improve health of high utilizers] …when there are social influences, there needs to be more than behavior change*."

The state of Connecticut's involvement in the Prevention Services Initiative as a convener is an asset.

Some interviewees noted that the state of Connecticut is a logical entity for bringing together healthcare and CBO players, and facilitating the development of networks. One interviewee explained that, "*the state had a better chance of getting the healthcare organizations to the table. It certainly hasn't worked with the CBOs trying to get the healthcare organizations to the table*."

Early Learnings from the Prevention Services Initiative

The concept of healthcare entities *buying* rather than *building* human services was not universally supported.

Most interviewees noted that, whenever possible, healthcare should seek to first *buy* instead of *build* human services. However, a few interviewees stated that some healthcare stakeholders, particularly those who employ community health workers in clinical settings, are not convinced of the value of *buying* services from CBOs rather than *building* them internally. Particularly when discussing programs relative to asthma and diabetes, some interviewees stated that healthcare entities viewed CBOs' work as duplicative of existing internal programs that train, educate, and refer patients. For example, frontline staff at one healthcare entity questioned, "*we do this, we educate patients, we teach them how to manage diabetes, why do we need help?*" Additionally, healthcare stakeholders explained that it's easiest for them to build services internally so that they can "*control the product*" and "*document outcomes*."

Community-based organizations are recognized for their work on the social determinants of health that often have a disparate impact on high healthcare utilizers.

Both healthcare and CBO stakeholders recognized that CBOs are uniquely positioned to work with hard-to-reach and vulnerable populations that are negatively impacted by the SDOH and are also often high utilizers of healthcare. As one interviewee noted, *"[health education] "alone won't move the needle*". While some healthcare stakeholders were hesitant to *buy* external services, there was interest in exploring how CBOs could work with high utilizers whom healthcare has historically been unsuccessful in engaging. For example, one healthcare stakeholder explained, "*Do we have cultural barriers we neglected? I don't know. That's the purpose of us participating in PSI*." However, a few stakeholders noted that interventions provided by CBOs to address the SDOH are often time and resource intensive and/or address small caseloads, which can lead healthcare institutions to pressure CBOs to streamline and remove some components of evidence-based models. As a solution, one interviewee proposed developing a "menu" that includes different services and pricing structures based on patient level of need, as well as criteria that healthcare entities could use to make referrals to different levels and prices.

Community-based organizations and healthcare entities have different views about how to approach value-based payments.

Healthcare interviewees expressed interest in having CBOs' reimbursement include a payment or bonus payment withholding based on the achievement of outcome measures. For example, one healthcare interviewee suggested that CBOs be required *"to reach [a] certain set of goals [such as improvement in A1C or attendance at appointments] to get part of [their] payment*," noting that "*we're a business. That's our perspective*." Healthcare entities expressed concern about whether CBOs would agree to having a portion of their payment depend upon outcomes and whether CBOs would be able to demonstrate an ROI. All CBO interviewees were hesitant to have their payment based entirely on outcomes given that CBOs do not maintain reserves of funds that could be used to cover costs if desired results were not achieved. In the words of one CBO interviewee, "*There is no way we would [take on risk]. Community health workers (CHWs) make very little money. It's crazy to think we're going to hire and train CHWs to work with people who are complicated and not have the funds to pay that person. That's insane."* Some CBOs noted that they could participate in a financing model that distributed shared savings or provided an outcome-based payment, as long as their minimum baseline costs (e.g., staff time) were covered.

Some CBOs also noted that their services could potentially result in cost savings (e.g., avoidance of emergency department utilization and/or prevention of procedures like amputation) and expressed interest in sharing these savings with healthcare entities.

Anticipated Opportunities and Challenges

There is potential to build trust and strengthen relationships across healthcare and human services sectors, at both the leadership level and among frontline staff.

A few interviewees noted the existence of strong relationships between healthcare entities and CBOs due to previous collaborations, such as the Primary Care Action Group in Bridgeport, a coalition of hospitals, health departments, health centers, and community-based and non-profit organizations that collaborates on community health improvement planning. In the words of one stakeholder, having these relationships had built "*a great foundation… now we're ready to go to the next step in 'marrying' medical treatment or medical care with prevention*." However, other stakeholders noted that there is a need to strengthen connections between community and clinical entities. A few interviewees shared the perception that healthcare entities may not view CBOs as sophisticated, evidence-based entities and therefore "*don't trust them to do [a] good job*." Interviewees praised the opportunity to showcase CBOs' work and build connections through the PSI TA mechanisms, noting "*it's like the dating game or something*." Interviewees noted that it is not only important to build buy-in among executive leaders, but also among frontline staff. As one interviewee noted, healthcare leadership "*are not necessarily communicating to the floor nurses [who are] already so overworked [that when they are asked to partner with a CBO they say] 'no, I can't do another thing*.'"

Pricing of CBO services and negotiation of opportunities for collaboration are key next steps.

Some healthcare stakeholders noted that they are eager for CBOs to approach them and market their services and value, including proposing how to operationalize working together. As one healthcare interviewee noted, *"[No CBO has yet come to them and said] 'here's what we do for the patient, here are the characteristics of a population we work well with… this is where we have been effective*." CBOs, on the other hand, noted that they are carefully working on pricing services and considering their capacity. Some CBO interviewees explained that, historically, they have not priced services in a "cost per client" model, and that, as they work through monetizing services, they must consider fixed costs and variable costs, as well as how to blend and braid funding from other sources (e.g., grants and municipal budgets). Additionally, expecting that there may be a need for increased capacity with an enhanced volume of referrals, some CBOs were considering how to build training costs for new staff into pricing of services. Negotiations between clinical and community entities regarding goals, objectives, and outcomes were seen as key next steps, and as one interviewee noted "*That hasn't happened yet, but it's what I'm looking forward to. If we don't do it soon I'm afraid we'll lose momentum*."

If successful, the Prevention Service Initiative will enhance sustainability and establish a model that can be spread.

Stakeholders expressed the hope that, if successful, the PSI initiative would be viewed as a best practice and that other healthcare entities working within value-based payment markets would establish similar types of relationships with CBOs. One interviewee did note that, if the PSI initiative is not successful, it could also be politicized and presented as a model for collaboration that should not be replicated. Additionally, CBO stakeholders were hopeful that the PSI initiative would demonstrate a sustainable financing mechanism (as opposed to grant funding) for supporting, in an ongoing fashion, community services that help individuals prevent and manage chronic conditions and avoid emergency care.

Case Study: Massachusetts Accountable Care Organization and Community Partner Model

Massachusetts has recently begun to move Medicaid beneficiaries into ACO models. All ACOs are required to work with Community Partners (CPs). The state provides specific guidance on and investments in relationships between healthcare entities and the CPs who come from the human services sector. Six interviews were conducted with six individuals involved in these models in Massachusetts. Interviewees included representatives from state agencies, MassHealth ACOs, and MassHealth CPs.

Model Overview

Background and State Context[14]

In 2018, Massachusetts implemented Medicaid delivery system reform with $1.8 billion in funding through the federal Delivery System Reform Incentive Payment Program (DSRIP), a five-year extension of an existing 1115 Medicaid waiver. The goals of the reform are to increase integration and coordination among providers across physical health, behavioral health (BH) and long-term services and supports (LTSS); reduce the rate of cost growth; transition from a fee-for-service payment system to accountable care; improve the member experience; and improve the quality of clinical care. Massachusetts is implementing these goals through new entities: ACOs and CPs.

Massachusetts Accountable Care Organization and Community Partner Model: Description and Population of Focus

Several states implementing DSRIP or DSRIP-like programs have created new provider entities that are responsible for the total cost of care and for addressing its members' SDOH. These models include Coordinated Care Organizations in Oregon, Accountable Entities in Rhode Island, Performing Provider Systems in New York, and Accountable Communities of Health in Washington State. Massachusetts is unique, however, in its $500 million direct investment in CBOs called CPs. CPs are contracted to provide community-based care coordination for approximately 5% of the MassHealth population that is highest cost and highest need and who have serious mental illness, substance use disorders, or disabilities that require long-term services and supports. Massachusetts has invested in both care coordination and the development of collaborative care delivery systems with ACOs and MCOs. Massachusetts is making this direct investment in CBOs with the goal of demonstrating over five years that CBOs, working alongside ACOs, can reduce costs for high need members by coordinating care across silos of care and connecting members to services that address SDOH. At the end of the five-year program, if CPs have demonstrated positive outcomes, the expectation is that ACOs and MCOs will contract directly to provide community-based care coordination and address health-related social needs of high cost, high need people.

MassHealth Accountable Care Organizations

MassHealth, the Medicaid agency in Massachusetts, has organized its delivery system reform through ACOs and MCOs. Across the Commonwealth, there are 17 ACOs as well as two MCOs that will include Primary Care Providers (PCPs) not participating in an ACO. All but four of the ACOs are actually partnerships between MCOs and health systems. Massachusetts is investing $1 billion in DSRIP funds over five years in these ACOs and MCOs. These funds may be used for start-up and infrastructure development as well as for the funding of "Flexible Services" to pilot innovative approaches to social service integration and address SDOH. In March 2018, approximately 950,000 MassHealth members were assigned to an ACO or MCO based on their previous primary care relationship.

MassHealth Community Partners

As part of its system delivery reform, MassHealth procured CBOs to serve as Behavioral Health Community Partners (BHCPs) or LTSS Community Partners (LTSSCPs). CPs will collaborate with ACOs to provide care coordination for approximately 5% of the MassHealth population with high behavioral health needs and/or high long-term services and supports needs. CP entities are often a collaboration of several CBOs that deliver BH and LTSS services. CPs, like ACOs, are contracted for a specific geographic service area. Across Massachusetts, there are 18 BHCPs and nine LTSSCPs.

MassHealth is investing $500 million in CPs through two separate funding streams. The first funding stream is a PMPM payment after the CP performs care coordination services. This differs from other states implementing Medicaid delivery reforms where it is up to the accountable provider entity or managed care entity to contract with and pay CBOs directly. The second funding stream is infrastructure funding that is provided by the state to CPs in two lump sum grant payments each performance year and is calculated on a PMPM basis. Prior to the start of the program, CPs were provided a lump-sum investment of up to $450,000. These infrastructure funds support the development of the new organizational forms and systems as well as subsidize the hiring of care coordination staff prior to program start and while caseloads are building. In years two to five of the demonstration, the Executive Office of Health and Human Services will withhold a portion of the infrastructure payment subject to performance on the CP quality measure slate (a set of quality measures). The program investment in infrastructure will be the most generous in the early years and decreases over time with the expectation that CPs will become sustainable.

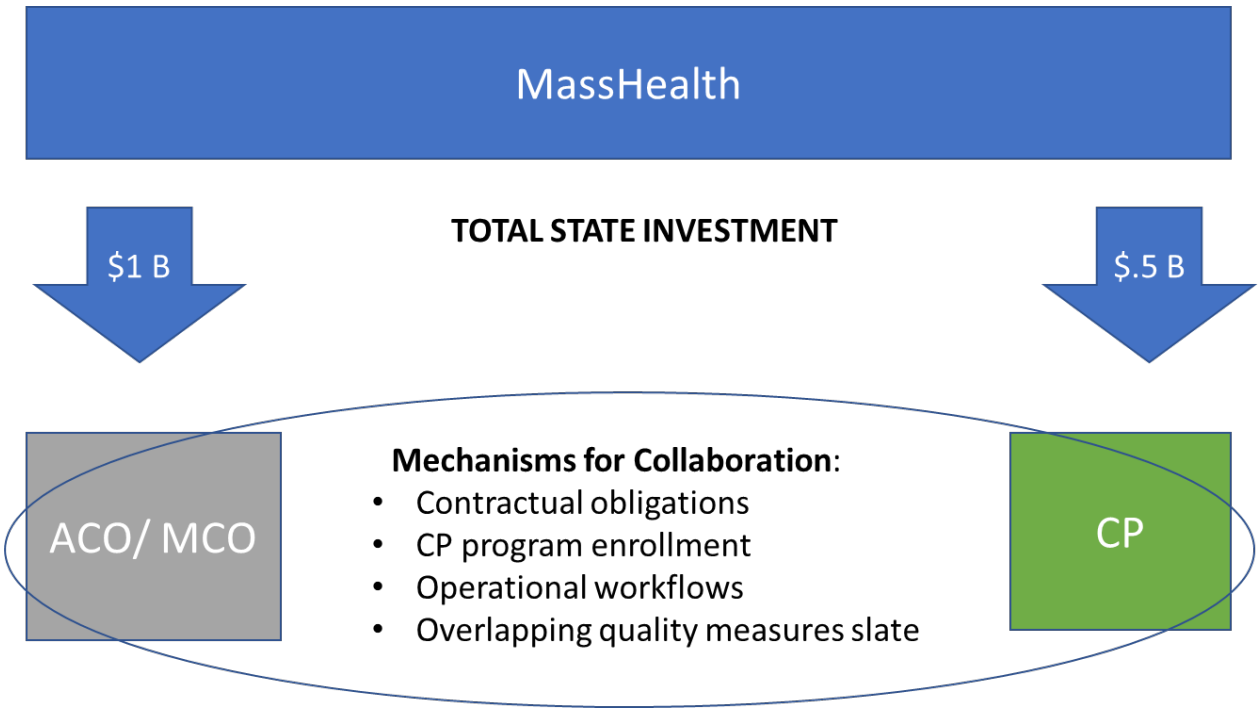
Flexible Services

An additional element of the MassHealth delivery system reform is the creation of a flexible services fund that ACOs can use to address their members' social service needs that are not otherwise covered by MassHealth. ACOs may use a portion of their DSRIP payment to support social services in two areas: 1) Housing search, placement and tenancy support; and 2) Nutritional support services. The program will begin in the middle of the second year (2019). At this time, MassHealth is requesting that ACOs develop a preliminary plan for investing their flexible services funds that includes specifying whether they intend to provide the social services themselves, partner with outside social/human services entities to provide the service, or simply purchase the service from a social service entity and not integrate the service or entity into the healthcare organization.

Mechanisms for Collaboration between Accountable Care Organizations and Community Partners

As shown in the figure below, the MassHealth ACO and CP model requires CPs and ACOs/MCOs to work together in many ways to better coordinate care across silos and connect people to non-medical services in the community that address social barriers. The structures for collaboration within this model fall under the following categories:

- **Contractual obligations**: all ACOs and CPs are required to sign agreements.
- **CP program enrollment**: MassHealth regularly sends BHCP- and LTSSCP-eligible members to ACOs and requires ACOs to refer those members to a CP within 30 days.
- **Operational workflows**: Before programs went live, ACOs and CPs were required to document key workflows, including the referral of eligible members by ACOs to CPs, the sharing of care plans by CPs with ACOs and obtaining PCP approval, sharing of service recommendations by CPs with ACOs and obtaining authorization when needed, and conflict resolution pathways.
- **Overlapping quality measure slate**: ACOs, BHCPs and LTSSCPs each have their own quality measures slate. About half of the CP measures are also ACO measures and about one-third of the ACO measures are also CP measures. Quality measure achievement determines the portion of at-risk infrastructure funds that entities receive.



MassHealth Model Development and Structure

Massachusetts chose providers of Behavioral Health and Long-term Services and Supports to be Community Partners in order to maximize potential for demonstrating results, including reduced healthcare costs and improved health outcomes.

During the development of the CP model, MassHealth considered procuring CPs that delivered services to meet social needs beyond those addressed through the BHCPs and LTSSCPs. However, MassHealth ultimately focused on investing in BHCPs and LTSSCPs because populations requiring these supports were driving high costs. MassHealth based their investment amounts on projected reductions in hospitalizations that it believed were achievable through community-based care coordination for high cost/high need members. Although leaders made an explicit decision not to directly address SDOH (e.g., nutrition or housing) beyond those already provided by BH and LTSS providers, CPs are required to screen for SDOH and make referrals to appropriate service providers. Many interviewees noted that there is value in incentivizing healthcare to collaborate with a broad range of human services providers addressing social needs. However, the focus of this demonstration model was narrowed to maximize the potential for impact. In the words of one interviewee, "*We believe the model will have ROI, but the only way to show that, to prove that, is to be prescriptive about how the model is set up*."

MassHealth procured and contracted with community-based organizations that it determined had certain experience, capabilities and infrastructure.

The state chose to undergo a procurement process for BHCPs and LTSSCPs to ensure that those selected had experience and met quality standards. Interviewees noted that, unlike some community service providers who historically had been under-funded and under-resourced, BH and LTSS providers generally had some experience working with electronic health records and managed care. In situations where CBOs on their own did not meet all the procurement requirements, they were encouraged to partner with others and apply as a consortium. Smaller CBOs that did not meet the requisite capabilities and who chose not to partner with other organizations were not selected.

Targeted infrastructure funding for Community Partners is a key element of this model.

A key and unique feature of this model, noted by many interviewees, is the direct infrastructure funding for CPs. As one interviewee stated, "*If ACOs are receiving infrastructure funding, why wouldn't CPs as well? Let's try to buck the trend about the historical disparity in investments into medical providers and CBOs*." In addition to ensuring that the selected CPs are qualified and experienced, another rationale for state procurement of CPs was to limit the number of CPs overall, thus allowing for significant investments in each of them. It was believed that diluting investments (i.e., providing insignificant amounts of funding to a large number of CBOs) would not yield demonstrable impacts.

Procurement of CPs by the state was intended to facilitate more balanced partnerships between community-based organizations and Accountable Care Organizations.

In addition to providing targeted infrastructure funding, the state decided to procure and pay the CPs directly (through the PMPM payment) rather than having funding flow through the ACOs. There was recognition of the historic under-investment in community-based entities and of the potential for power differentials if ACOs were to select and fund community-based partners. As one interviewee noted, "*If [the state] hadn't procured the CPs and everything was flowing through ACOs, that power dynamic would be heavily weighted toward ACOs."* Procurement of CPs by the state was intended to facilitate more balanced partnerships between CBOs and ACOs, and to assist both healthcare and human services in developing collaboration. Additionally, one interviewee noted that, prior to the development of this model, some ACOs had started to *build* BH services in-house. This model ensures that ACOs work with CBOs to coordinate care.

Early Learnings from MassHealth Model Implementation

Challenges in building effective relationships between Community Partners and Accountable Care Organizations remain.

While efforts have been made to balance some of the power differential between healthcare and human services entities, perceptions of unequal power and challenges to building effective relationships between these two sectors persist. Interviewees praised and appreciated the state's intent in establishing "equal footing" between CPs and ACOs, and stated that the "*fact that the state created a specific role for CBOs is huge*" and gave CPs *"legitimacy*." Additionally, ACOs and CPs have overlapping quality measures. However, it was also noted that the ACOs are accustomed to being dominant partners and that many ACOs are large hospital and health systems that bring sophisticated and well-honed expertise to negotiations. One stakeholder also noted two significant ways in which ACOs hold more power than CPs in the ongoing ACO-CP relationship: (1) Starting in the second year of the program, CPs will be dependent on ACOs for referrals; and (2) CPs are dependent on ACOs for review and approval of the care plan (CP payment from MassHealth is contingent upon care plan approval). Given these factors, as one interviewee noted, "*There's a power differential here. We all feel that every day*."

While Accountable Care Organizations and Community Partners are required to work together, variation in approach across multiple entities has led to complex and burdensome documentation and planning processes.

ACOs and CPs are required to collaborate with the designated entities in their service area, which includes developing working relationships, documenting specific protocols and processes for care coordination operations, and signing contracts and business agreements. In the words of one interviewee, "*Both ACOs and CPs [have] to develop working relationships and processes with so many entities… [to] manage that, train staff, is really the most chaotic thing I've ever seen in my entire career*." Many interviewees commented on the fact that there is variation in protocols and contracting for each ACO and for each CP. For example, statewide ACOs are developing protocols and contracts with all 27 CPs. As one interviewee explained to illustrate the administrative complexity and power differential, "*[An] ACO says to [the] CPs, 'We're just doing it one way with all CPs, we can't handle variation.' and CPs [are] having to fight back and say, 'I can't do it 14 different ways for each ACO!' [But] it's the ACOs prevailing*."

Connecting data systems to support care coordination is a challenge.

Capturing and sharing relevant data was consistently recognized as both an important aim and a challenge. Many interviewees commented on the importance of data systems to support communication and decision-making, noting that, "*Communication is key and it's complicated*." Additionally, CPs were required to have either an electronic health record or a care coordination system in place to win a CP contract. However, the development of connected information systems has been a challenge for both ACOs and CPs for two reasons. First, ACOs use different electronic health records, and second, there is no statewide electronic event notification system. One stakeholder noted that ACOs themselves, many of which are partnerships between large provider systems and MCOs, may already be struggling with integrating multiple systems within the ACO. Thus, integration with CP systems has not been a priority. In addition to data challenges around care coordination and referrals, some interviewees noted that CPs may lack internal data analytics capacity to support quality improvement activities. In the words of one interviewee, "*CBOs have little or no infrastructure around data collection, data analysis, [or] using data in decision-making*."

New payment structures require an adjustment for Community Partners.

In addition to infrastructure payments and PMPM payments for care coordination from the state, in some cases the CPs are also negotiating service contracts with ACOs. While most CPs have some experience with PMPM payments for care coordination, this type of payment structure has historically been a smaller part of their businesses relative to other types of contracts. It was noted that operationalizing new payment models within CPs *"requires different program management and different fiscal management*," especially for CBOs and long-time staff who are accustomed to being paid through state-agency cost reimbursement contracts and/or fee-for-service mechanisms. Additionally, when asked about the future of collaboration between community-based and healthcare organizations in general (i.e., beyond just the CP program), one interviewee shared additional potential challenges with alternative payment structures. "*PMPM or capitated rates or bundled payment models are all new, [so] lots of education [is] needed within organizations… Figuring out your cost, cost per episode, cost per care, even the concept of an episode is foreign to people*."

Anticipated Opportunities and Challenges

The establishment of formal relationships between Accountable Care Organizations and Community Partners is an accomplishment and opportunity for ongoing partnership.

While the challenges to developing formal relationships and contracts between ACOs and CPs were widely acknowledged, the establishment of these relationships was viewed by many as an accomplishment in and of itself. Those involved in the state's new model noted that, historically, these formal relationships did not exist, and that differences in culture, business models, and processes between ACOs and community providers remain and can be barriers to collaboration. Specifically, one stakeholder noted that some ACOs would have preferred to *build* care coordination programs internally, due to distrust and/or a lack of understanding of CBOs' capabilities. Nevertheless, in the words of one interviewee, "… *we now have these contracts, there are formalized relationships between medical providers and BH and LTSS community providers. I don't want to minimize how big of an accomplishment this is*."

Community Partner staff retention and referral volume is uncertain and will impact sustainability.

It was noted that ACOs and CPs may be concurrently hiring similar types of staff, such as nurses, social workers, and CHWs, but ACOs *"can pay a heck of a lot more"* than CPs. Therefore, the ability of CPs to hire and retain staff was cited as a concern. Some interviewees also noted that the volume of clients that will be identified by MassHealth and referred by ACOs to CPs is uncertain, and that the number of clients that actually agree to participate in CP programs is also unknown. Therefore, CPs are wondering, "*Will we get enough referrals to have a sustainable role?*" Staff retention and referral volume will influence CPs' operations and sustainability moving forward.

There is concern about limited funding and capacity for provision of direct human services.

Many interviewees remarked that the CPs in this model will "*get a PMPM to connect* [clients with care]", however, the model does not make any changes to direct service rates or funding availability for direct services. Though it does allow ACOs to develop direct relationships with human services providers, there is confusion around expectations for ACOs' use of flexible services funding. Some interviewees expressed concern that social needs would be identified among clients and patients, but that funding and capacity to support human services in addressing such needs would remain limited, resulting in a "*bridge to nowhere*". As one interviewee discussed, "*There's nothing in the model that will fundamentally change the way that direct services, not care management, but those direct services, are delivered or reimbursed... As ACOs and CPs identify more people with BH and social service needs, there's a big worry… Are there enough services to incorporate more and more people into services? …[We] could do a great job coordinating care, but if [there are] no services to get people to, that's the worry*."

The state's future involvement in this model is unknown.

Originally, the state intended that this model would produce an ROI that would incentivize ACOs to fund the work of the CPs. However, some interviewees stressed that this model is a demonstration, and that it is unknown whether the program will "*pay for itself over time*." A few interviewees noted that the state may need to continue to be involved in certain elements of the program in the future. Also, there was concern about defining ROI strictly in financial terms. As one interviewee stated, "*The reality is that because these members are so complex, so vulnerable, connecting them to better healthcare could actually increase costs. It's challenging to create a complete ROI. ROI needs to more than just financial. [The] quality of care piece of it is important*."

References

1. Bayley, K. B., Broffman, L., Brown, K., Rissi, J., & Savitz, L. (No date). Drive and Tension: CCO Case Studies. Providence Health and Services. Retrieved from https://oregon.providence.org/~/media/files/providence%20or%20pdf/corefullccocasestudy.pdf
2. Bonney, J., & Chang, D. (2017). Case Study: Medicaid and Public Health Collaboration in Oregon. *National Academy of Medicine*. Retrieved from https://nam.edu/wp-content/uploads/2017/04/Medicaid-and-Public-Health-Collaboration-in-Oregon.pdf
3. Health Policy and Analytics Division, Office of Health Policy. (2017). Health-related Services. Oregon Health Authority. Retrieved from https://www.oregon.gov/oha/HPA/CSI-TC/Resources/OHA-Health-Related-Services-Brief.pdf
4. Klein, S., McCarthy, D., & Cohen, A. (2014). *Health Share of Oregon: A Community Oriented Approach to Accountable Care for Medicaid Beneficiaries* (Case Studies of Accountable Care Systems No. 1769, Vol. 22). The Commonwealth Fund. Retrieved from https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_case_study_2014_oct_1769_klein_hlt_share_oregon_aco_case_study.pdf
5. Health Share of Oregon. (n.d.). My Health Plans: What Health Share Offers. Retrieved from http://www.healthshareoregon.org/for-members/my-health-plans.html
6. Innovation Café Improving Key Health Metrics: Tri-County 911 Service Coordination Program (TC911). (2017). Oregon Health Authority. Retrieved from https://www.oregon.gov/oha/HPA/CSI-TC/Documents/Emergency-department-project-handouts.pdf
7. State of Connecticut. (2013, December 30). Connecticut Healthcare Innovation Plan. State of Connecticut. Retrieved from https://www.healthreform.ct.gov/ohri/lib/ohri/sim/plan_documents/ct_ship_2013_12262013_v82.pdf
8. State of Connecticut. (2018, February 1). Connecticut State Innovation Model Operational Plan: Award Year 3 Update. Connecticut State Innovation Model. Retrieved from https://portal.ct.gov/-/media/OHS/SIM/sim_operational_plan_ay3_narrative_1-22-18_revisedfinal_submitted.pdf
9. RTI International. (2017). *State Innovation Models (SIM) Round 2: Model Test Annual Report One* (Model Test Annual Report No. 1). Research Triangle Park, NC: RTI International. Retrieved from https://downloads.cms.gov/files/cmmi/sim-round2test-firstannrpt.pdf
10. Connecticut Department of Social Services. (2018). *Five Key Points About Connecticut HUSKY Health (Medicaid and CHIP)*. PowerPoint. Retrieved from https://portal.ct.gov/-/media/Departments-and-Agencies/DSS/Communications/HUSKY-Health---Five-Key-Points.pdf?la=en
11. Connecticut Hospital Association. (2018, January 18). Connecticut Hospitals Launch Test Project to Focus on Social Determinants of Health. Connecticut Hospital Association. Retrieved from https://www.cthosp.org/CHA/assets/File/newsroom/pr/Hospitals%20Launch%20Test%20Project%20on%20Social%20Determinants%20of%20Health.pdf
12. State of Connecticut. (n.d.). State Contracting Portal Solicitation Details. Retrieved from https://biznet.ct.gov/SCP_Search/BidDetail.aspx?CID=45353

13. Tabbush, V. (2012). *Overview of Preparing Community-Based Organizations for Successful Health Care Partnerships* (Preparing Community-Based Providers For Successful Health Care Partnerships). Long Beach, CA: The SCAN Foundation. Retrieved from http://www.thescanfoundation.org/sites/default/files/tabbush-cbo_healthcare_prtnrshps-8-22-12.pdf

14. Ash, A., Mick, E., Ellis, R., Kiefe, C., Allison, J., & Clark, M. (2017). Social Determinants of Health in Managed Care Payment Formulas. *JAMA Intern Medicine*, *177*(10), 1424–1430. https://doi.org/10.1001/jamainternmed.2017.3317