



Incorporating Community-Based Organizations in Medicaid Efforts to Address Health-Related Social Needs: Key State Considerations

April 2023

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ACKNOWLEDGEMENTS

To support this report, CHCS spoke with state Medicaid staff from **California, Massachusetts, New York, North Carolina,** and **Oregon** and subject matter experts from the **California Pan-Ethnic Health Network; Camden Coalition; Nonprofit Finance Fund; USAging;** and **BlueCross BlueShield of Tennessee.** CHCS thanks them for their participation.

This report was made possible by the **California Health Care Foundation,** which works to ensure that people have access to the care they need, when they need it, at a price they can afford. Visit www.chcf.org to learn more.

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The Center for Health Care Strategies (CHCS) is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid. We support partners across sectors and disciplines to make more effective, efficient, and equitable care possible for millions of people across the nation. For more information, visit www.chcs.org.

Introduction

State Medicaid programs are increasingly connecting the dots between the medical, behavioral, and social components of health to achieve the goal of more equitable, whole-person care.¹ Emerging state initiatives are addressing the health-related social needs (HRSN) of Medicaid enrollees, which account for as much as 50 percent of health outcomes.² Developing HRSN interventions that are locally focused, culturally congruent, and community-centered requires partnerships with community-based organizations (CBOs) that specialize in social care, like food and housing services.

Both states and federal agencies have encouraged more integration of CBOs into the traditional health care landscape.³ State Medicaid agencies increasingly require health care organizations (HCOs) like managed care organizations (MCOs), accountable care organizations (ACOs), and providers to partner with CBOs.⁴ And new guidance from the Centers for Medicare & Medicaid Services (CMS) on HRSN services will likely expand the impact of these relationships. In December 2022, CMS announced a new 1115 demonstration opportunity that allows states to cover HRSN services as Medicaid benefits for individuals with relevant clinical and social risk factors.⁵ In January 2023, CMS provided additional guidance encouraging the use of in lieu of services to address HRSN via Medicaid managed care and supporting partnerships with CBOs to provide HRSN-related services.⁶

While CBOs often partner with the health care sector, there is limited evidence on how states can foster effective collaborations between CBOs and HCOs successfully.⁷ However, some states have sought new ways to strengthen CBO-HCO relationships as part of their Medicaid transformation initiatives.

This report explores insights from early state innovators to help guide states, HCOs, and CBOs in shaping and navigating successful CBO-HCO relationships. The Center for Health Care Strategies (CHCS) examined leading-edge states with Medicaid programs requiring formal CBO-HCO partnerships to uncover lessons for incorporating CBOs into Medicaid HRSN initiatives (see [Appendix](#) for program features). CHCS interviewed subject matter experts and stakeholders to identify best practices and implementation considerations for other states interested in strengthening CBO-HCO partnerships.

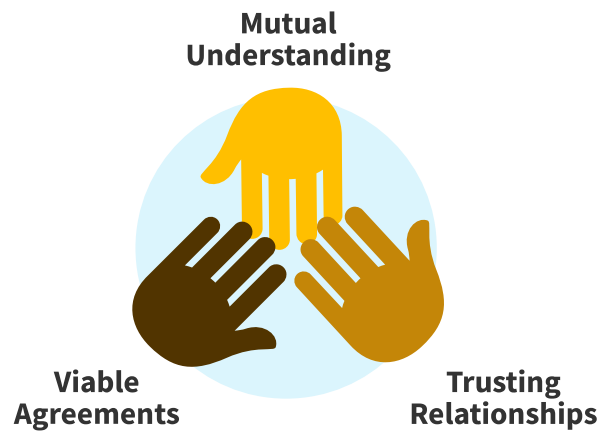
TAKEAWAYS

- Supporting and engaging community-based organizations (CBOs) is integral to advancing whole-person, equitable care.
- State Medicaid agencies have begun to encourage the participation of CBOs in new health-related social needs (HRSN) initiatives and hold health care organizations (HCOs) accountable for this work. But these approaches are new, with little available evidence on which state policies are effective.
- Based on interviews and a scan of activities in leading-edge states, this report outlines essential elements for building successful cross-sector partnerships, as well as recommendations to guide states as they seek to develop a more equitable health and social care ecosystem.

Drawing from early state innovators, this report outlines three essential elements needed for successful CBO-HCO partnerships, including **mutual understanding**, **trust between organizations**, and **viable operational and financial agreements**. It describes the following four key considerations for how state Medicaid agencies can support CBOs and HCOs to achieve successful partnerships:

1. **Create roles for CBOs and Community Care Hubs in transformation initiatives.**
2. **Establish dedicated funding and CBO-HCO contract guidance.**
3. **Ensure equitable access to HRSN services.**
4. **Assess impact on health outcomes and disparities.**

Essential Elements of Successful CBO-HCO Partnerships



Medicaid agency supports success through:

policy development, CBO-HCO contract supports, monitoring and oversight, and evaluation



Create roles for CBOs and Community Care Hubs in transformation initiatives



Establish dedicated funding and CBO-HCO contract guidance



Ensure equitable access to HRSN services



Assess impact on health outcomes and disparities

Essential Elements for CBO-HCO Partnerships

To effectively address Medicaid members' whole-person needs, CBOs and HCOs will need to form new relationships and implement structural and process changes to integrate these new partners into their day-to-day work. These partnerships have several dimensions, such as governance, data sharing, financing, and service models, and may require changes at the partner level, community level, and policy or systems-level.⁸

There are often power imbalances and organizational cultural differences between CBOs and HCOs, which affect both contracting terms and organizational partnerships. To help form equitable CBO-HCO partnerships, CBOs and HCOs need: (1) **mutual understanding**; (2) **trust between organizations**; and (3) **viable operational and financial agreements** for both partners. Medicaid agencies can create policies that help foster partnerships with these attributes, as discussed in the [Key State Considerations](#) section of this report.

1. Mutual Understanding

CBOs and HCOs are separate entities with distinct goals. While these organizations typically share the mission of improving lives of individuals and communities, differences between organizations — such as vision of success, terminology used, and training and ways of doing business — can create barriers. For example, improved health outcomes would be important to an HCO, but a CBO that provides nutritious meals to the community is unlikely to track that metric. Co-developing shared goals and metrics that resonate with both parties are crucial to effective partnership and achieving shared success.

In the same vein, HCOs should find common ground with CBOs and avoid trying to “medicalize” CBOs. For example, CBOs that provide only HRSN services are often not HIPAA-covered entities, and may have difficulty complying with data protections intended for medical providers.⁹ Recent federal guidance has underscored the ability of covered entities to transmit basic health information to CBOs and social service agencies, such as housing providers.^{10,11} Nonetheless, CBO-HCO partnerships will involve iterative discussions on what protections and flexibilities are necessary to forge a workable partnership. And while these discussions take time, they are critical to support partnerships where both entities feel valued.

Community-Based Organizations: Key Terms

For purposes of this report:

A **Community-Based Organization** (CBO) is an organization that works at a local level to address the HRSN of community members, either through direct service delivery or non-clinical care management. Examples include food banks and pantries, asthma remediation providers, housing supports, and community health worker organizations specializing in care management.

A **Community Care Hub** is a community-focused entity that organizes and supports a network of CBOs providing services to address HRSN.

2. Trust Between Organizations

Many interviewees emphasized that trust needs to be built before and during the contracting process, and continue throughout the partnership. Trust can be the determining factor in whether a contract is ultimately executed, and whether the partnership will be effective for the communities served. It is rare to have a contractual relationship that satisfies both sides completely. However, if trust can be built, it is more likely that parties can work through ambiguity or difficulties to meet their shared goals.

HCOs can foster trust by providing upfront funding, fully engaging CBOs to co-design processes and respective roles, and helping CBOs ease into new requirements. Initial partnership conversations should center on supports that will help partnerships grow over time and improve care for Medicaid members. In addition, states and HCOs can appropriately tailor Medicaid participation requirements for CBOs providing HRSN services and prevent any unnecessary burden. For example, HCOs can consider changing insurance coverage requirements in boilerplate network provider contracts, which often exceed typical insurance coverage offered to CBOs.¹²

HCOs can also build trust by identifying and reducing interested CBOs' barriers to entering into Medicaid contracts. HCOs sometimes require CBOs to navigate complex administrative and credentialing processes to simply be considered for a contract, which may deter CBO participation and erode trust. Some CBOs may prefer state programs that require centralized, one-time submission to the state with uniform terms, rather than to each HCO separately with unique requirements for each.

Information sharing among CBOs and HCOs is also essential to building trust. This includes not just data, but information about state initiatives and related requirements. Power dynamics and unequal access to key information typically creates a disadvantage for CBOs when negotiating contracts. In developing CBO contracting teams, HCOs can deploy individuals who have experience working in CBOs to serve as a liaison between the organizations, and establish a more comprehensive partnership between both teams, beyond a transactional vendor relationship.

Resources for CBO-HCO Partnerships

Following are a variety of practical resources to help CBO and HCO partners build and enhance effective and supportive relationships.

- [One-Stop Shop for Healthcare & Community Partnerships](#) (HealthBegins, Nonprofit Finance Fund)
- [Partnership Assessment Health Tool and Advancing Health Equity Addendum](#) (Nonprofit Finance Fund, CHCS, Alliance for Strong Families & Communities)
- [Nonprofit Readiness for Health Partnership](#) (Nonprofit Finance Fund, CHCS, Alliance for Strong Families & Communities)
- [Community Care Hub Working Documents](#) (Partnership to Align Social Care)
- [Working with Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies](#) (Manatt Health)
- [The Role of Community-Based Organization Networks in CalAIM: Seven Key Considerations](#) (CHCS)

3. Viable Operational and Financial Agreements

Contracts between CBOs and HCOs should be mutually beneficial and build on the respective strengths of each organization. CBOs have intimate knowledge of the HRSN services they deliver and the communities they serve, but may be operating with limited staff and financial resources. If CBO processes, staffing, and workflows need to be modified to accommodate the health care partnership, CBOs need upfront funding as well as sufficient ongoing funding and staffing to sustain this work over time. HCOs can also provide in-kind resources. For example, HCOs can provide support and dedicated staff to help with data analysis, rather than CBOs having to upgrade their technology.

Power dynamics between CBOs and HCOs can affect contract negotiations and ongoing partnerships, and also influence discussions about workflows, data reporting, and rates. In addition, small to midsize CBOs are less likely to have the capacity and experience to enter contractual relationships with HCOs on their own. In response, some CBOs have considered forming CBO networks, or community care hubs.¹³ Community care hubs can support a network of CBOs providing services to address HRSN, and centralize administrative functions and operational infrastructure, including but not limited to, contracting with HCOs, payment operations, management of referrals, service delivery fidelity and compliance, technology, information security, data collection, and reporting.¹⁴ Notably, this centralization may work in some, but not all environments. States can critically assess these tools and structures in the context of other policies that promote a more equitable health and social care ecosystem.^{15,16}

Key State Considerations to Support Successful CBO-HCO Partnerships

CBO-HCO partnerships can vary widely, and Medicaid initiatives that incorporate CBOs and HRSN services are relatively nascent. Up until now, states have broadly encouraged MCOs and HCOs to forge new partnerships and expand HRSN service offerings, but have not monitored access, impact, or quality for these services in the same ways as Medicaid benefits. However, this more flexible approach will likely change in the near future.

As states increasingly require CBOs and HCOs to form new partnerships to fund and deliver services in a coordinated, person-centered way, state and federal entities are creating ways to monitor the efficacy of these new relationships. For example, through the 1115 demonstration, CMS requires states to outline how they will manage HRSN provider shortages and other access barriers, as well as develop robust evaluation criteria to ensure CBOs are held to utilization and quality standards for HRSN interventions.¹⁷

With recent CMS guidance related to HRSN, Medicaid initiatives will likely rapidly mature, and states will establish processes to ensure timely, equitable access and address provider shortages.

Following are four key considerations, including examples of early state innovators, that can help guide states embarking on this work.

1. Create Roles for CBOs and Community Care Hubs in Transformation Initiatives

State Medicaid agencies are increasingly prioritizing activities to address HRSN. Because many of these initiatives are new, states often adopt very general goals, such as increasing MCO partnerships with CBOs writ large, but it is helpful to define goals and priority areas.



For example, many different types of organizations can be considered a CBO. In refining their focus, states can identify what types of CBOs best address identified needs, and define goals based on those narrower categories. For example, states may want to prioritize partnerships with CBOs that have certain domain expertise, like housing providers or food banks. States should also center explicit health equity goals, such as integrating CBOs with strong connections and trust within their communities (e.g., Black- or Latino-led organizations).

States with early HRSN initiatives often defined categories of CBOs based on the needs of their programs and initiatives. For example, **Massachusetts** and **North Carolina** select CBOs specializing in care coordination and management to perform key functions in their Medicaid transformation initiatives.^{18,19} Both **New York** and **Oregon** expect their managed care entities to partner with certain types of CBOs.^{20,21}

States can also support the development of community care hubs. In **North Carolina**, “Network Leads” — typically larger CBOs that specialize in case management — manage the state’s Healthy Opportunity Pilots and networks of specialized CBOs (“human services organizations”) that provide services like food and home modifications.²² The state expects Network Leads to create CBO networks that meet the state’s broad network sufficiency and efficiency requirements. Under its new 1115 waiver, **New York** proposes the creation of groups of CBOs called Social Determinants of Health Networks to support these functions.²³ The state proposed this concept after noting that existing value-based payment requirements limited the scale of HRSN interventions in the state, and more funding and related support was needed to grow networks and enable community resource referral tools.²⁴

Exhibit 1 through 3 outline some early definitions of CBOs and CBO networks, and their role in Medicaid transformation initiatives.

Exhibit 1: CBO-HCO Partnerships for HRSN Services

STATE	HRSN SERVICES
California	Community Supports providers include CBOs that offer asthma remediation, housing supports, and medically supportive food.
Massachusetts	ACOs can contract with CBOs that provide health-related social services, like nutrition and housing supports, via the Flexible Services program. Most ACOs partner with a CBO (or “ Social Service Organization ”) for Flexible Services.
New York	To support its value-based purchasing initiatives, the state designated three tiers of CBOs, classifying CBOs based on the services they provide and their Medicaid billing status. The state focused on Tier 1 CBOs: “Non-profit, non-Medicaid billing, community based social and human service organizations (e.g., housing, social services, religious organizations, food banks).”
Oregon	Coordinated Care Organization (CCO) contractual requirements around reinvestment and community partnerships include the term Social Determinants of Health and Equity Partner (“ SDOH-E Partner ”) defined as a “single organization, local government, one or more of the Federally recognized Oregon tribal governments, the Urban Indian Health Program, or a collaborative, that delivers SDOH-E related services or programs, or supports policy and systems change, or both within a CCO’s service area.”

Exhibit 2: CBO-HCO Partnerships for Care Coordination and Management

STATE	CARE COORDINATION AND MANAGEMENT
California	Enhanced Care Management providers include CBOs that specialize in services for older adults, individuals experiencing homelessness, justice-involved populations, and pregnant people.
Massachusetts	Accountable care organizations contract with the state’s designated 27 Community Partners in their service area. Community Partners specialize in providing care coordination supports for members either with behavioral health or long-term services and supports needs. In the next phase of its waiver, MassHealth will require ACOs to contract with a minimum number of, but not necessarily all, Community Partners in their area.

Exhibit 3: Partnerships with Community Care Hubs/CBO Networks

STATE	COMMUNITY CARE HUBS/CBO NETWORKS
New York	New York’s proposed 1115 demonstration includes Social Determinants of Health Networks (SDHNs) and Health Equity Regional Organizations (HEROs) as a central component. SDHNs are coordinated CBO networks that help CBOs work together to create supportive IT and business processes infrastructure, and adopt interoperable standards for a social care data exchange. HEROs are mission-based organizations that build a coalition of HCOs, CBOs, provider organizations, consumer representatives, and other stakeholders to advance health equity.
North Carolina	State-selected Network Leads (often larger CBOs that specialize in case management) manage the state’s Healthy Opportunity pilots and networks of specialized CBOs (called “human services organizations”) that provide pilot services in four domains: food, housing, transportation, and interpersonal violence/trauma, in addition to cross-cutting domains like legal support.
Washington	Washington has proposed creating Community Hubs to support community-based care coordination that focuses on HRSN and community-based services. Hubs would be managed by the state’s existing Accountable Communities of Health . The state also proposes a Native Hub, to be managed by a to-be-defined entity in consultation with the state’s Tribes and the Governor’s Indian Health Advisory Council.

2. Establish Dedicated Funding and CBO-HCO Contract Guidance



States can create formal programs that make Medicaid funding available for HRSN services provided by CBOs, or more flexible initiatives that defer to individual HCOs to craft interventions relevant to their members. For example, states can consider state plan amendments authorizing community health worker services, in lieu of services voluntarily provided by MCOs, or demonstration programs making food, housing, and related case management services more like a benefit.²⁵ In more flexible approaches, states can encourage HCOs to enter into CBO partnerships as part of value-based payments or to support community-based care management.²⁶

To support these more advanced initiatives, states have created resources to promote fairer contracting, and fast track partnership development. For example, both **California** and **North Carolina** created model contracts, and suggested rates for the HRSN services in their programs (see **Exhibit 4**, next page, for additional details). **California** made its rate guidance “non-binding,” and allowed its managed care plans to develop rates that were responsive to its counties’ needs and attributes, such as high real estate costs in the San Francisco Bay Area. In future years, states may want to assess how more flexible payment models support the unique ways CBOs do business, building on lessons from value-based payment models with health care providers.

Exhibit 4: Sample State Approaches to CBO Contracts and HRSN Service Rates

STATE	MODEL CBO CONTRACTS AND GUIDANCE	RATES FOR HRSN SERVICES
California	The state developed Provider Standard Terms & Conditions for Enhanced Care Management and Community Supports providers. It also developed Data Sharing Authorization Guidance .	The state’s Non-Binding Pricing Guidance features midpoint ranges and rate ranges for Community Support (but not Enhanced Care Management) services. Managed care plans have “full flexibility and discretion” to use other rates.
North Carolina	The state provides two model contracts relating to CBO partnerships: the Network Lead-HSO Model Contract and the PHP-Network Lead Model Contract .	The Pilot Service Fee Schedule provides rates and caps for 29 pilot services, including per member per month rates, cost-based reimbursement, and per diems.

States and HCOs can also invest in financial, technological, and technical assistance resources to jumpstart partnership development and strengthen CBO capacity (see **Exhibit 5** for state examples). Some states provide funds directly to CBOs, and others expect their contracted partners, like Network Leads, MCOs, or ACOs, to distribute funds to CBOs. Both approaches can have delays and information gaps. HCOs and states can manage these delays via frequent, transparent communication with CBOs and, where appropriate, bridge funding. Recently approved 1115 demonstrations in **Arizona, Arkansas, Massachusetts, and Oregon** include funding for “HRSN Infrastructure,” in four areas: (1) technology; (2) development of business or operational practices; (3) workforce development; and (4) outreach, education, and stakeholder convening.²⁷

Exhibit 5: Examples of State Investments in CBO Capacity

STATE	CAPACITY-BUILDING FUNDS
Arizona	The CommunityCares CBO Incentive Program allows CBOs to earn up to \$10,000 for joining the state’s closed loop referral system and meeting usage metrics.
California	Through the Providing Access and Transforming Health (PATH) Capacity and Infrastructure Transition, Expansion and Development (CITED) initiative , the state directly provides funds to Community Supports and Enhanced Care Management providers — including CBOs — to support workforce, health information exchange, and physical infrastructure (e.g., replacing infrastructure that refrigerates fresh food), among other activities. Managed care plans may also provide similar funding to CBO providers, as supported by the Incentive Payment Program . In addition, CBO providers can receive technical assistance through the PATH Technical Assistance Marketplace .
Massachusetts	Massachusetts has historically invested in strengthening CBO capacity to enter into health care partnerships, including through the Massachusetts Upstream Investment Program , the Social Services Organization Flexible Services Preparation Fund , and the future Social Services Organization Flexible Services Integration Fund . Community Partners specializing in behavioral health and long term services and supports received funding through the state’s previous 1115 demonstration , and the recently approved demonstration .

3. Ensure Equitable Access to HRSN Services

Medicaid is relatively new to the world of providing HRSN services. As initiatives mature, states will likely see initial successes along with a variety of barriers impeding the effectiveness of CBO participation in providing HRSN services. To advance delivery of HRSN services, states can define accountability measures and standards for HCOs participating in their Medicaid programs, ensuring HCOs are charged with developing partnerships with a wide range of CBOs and supporting CBO capacity building as needed.



To ensure equitable access to HRSN services, states can:

- **Center member experience of care.** States can create service definitions that are responsive to member’s needs and realities — for example, considering the household unit when providing food supports to members.²⁸ In addition, states can monitor members’ experiences with particular CBO providers and HCOs responsible for authorizing the HRSN services, and ensure that services are high-quality and timely. States and HCOs can monitor members’ grievances and complaints, and create a range of opportunities for community engagement, co-design, and feedback — especially within communities that are marginalized. States can assess barriers to access, such as state or HCO documentation or authorization requirements that can delay care and referral. For example, **California** has required its managed care plans to develop expedited authorization timeframes for recuperative care, short-term post hospitalization housing, sobering centers, and medically tailored meals offered post-acute care.²⁹

Networks and Access: Key Terms

Provider networks help Medicaid members get the care they need. As Medicaid covers new HRSN services, states/HCOs will need to explore new provider enrollment pathways for CBOs, and new approaches to network monitoring and oversight.

- **Network Sufficiency/Adequacy:** State/HCOs build a network that ensures that members can reasonably access the services they need, in a timely manner. State/HCOs have policies and procedures to manage provider shortages or other barriers.
- **Network Efficiency:** Each contracted network provider offers services to enough Medicaid members to make participation in the Medicaid network viable for the provider, and to optimize administrative expenses for the state or HCO overseeing the network.
- **Equitable Access:** Medicaid members have timely access to services, in or near the communities they live. HCOs recruit, and invest in, network providers that center trust, dignity, and cultural humility in the delivery of services, and encourage culturally congruent and linguistically accessible care, whenever possible.

- **Require HCOs to have dedicated staff for CBO partnerships.** States can require HCOs to designate and assign staff to help with CBO referrals or report on CBO-related activities. **Exhibit 6**, below, highlights examples of state requirements for HCO staffing and reporting requirements.

Exhibit 6: Examples of HCO Staffing and Reporting Requirements for CBO Partnerships

STATE	REQUIREMENT
Arizona	Arizona MCOs must have a designated housing specialist , which manages the provision of housing and housing resources to members within the Contractor’s service area and serve as a liaison to the local Continuum of Care.
California	California’s Incentive Payment Program requires that MCOs submit a narrative plan describing how it will partner with CBOs, among other service providers, and develop strategies for closing health disparities.
New Jersey	New Jersey MCOs must have an assigned housing coordinator for individuals with long-term services and supports needs.
Hawaii	Hawaii’s Behavioral Health Organization Case Managers assist with housing assessment and plan of service and refers member to case management/homelessness agencies that provide community integration services.
Tennessee	TennCare MCOs enter into provider partnerships to support the Health Starts initiative, which among other functions, helps with CBO closed loop referrals and related quality improvement initiatives.

- **Examine service availability.** Social services have historically been underfunded, relative to health care, and initial gaps in HRSN services will likely be the norm, rather than the exception. Few states have applied measures of network adequacy or sufficiency to HRSN-focused initiatives, but some plan to adopt measures in the future. Pinpointing the role of CBOs in networks will be new territory for many Medicaid agencies. Quantitative network adequacy standards developed by states for health care services — like provider-to-enrollee ratios, time and distance standards, and appointment wait time — may not gauge participation of CBO providers in particular, or may obscure or underplay the importance of small, culturally congruent providers with a deep community connections.³⁰ New federal flexibilities and opportunities will require states to develop similar monitoring and oversight standards for HRSN services, but CMS will likely defer to states to develop specific measures and oversight mechanisms. For example, **Massachusetts** must ensure that HRSN services covered in their 1115 demonstration are delivered to eligible members in a timely manner and “develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision.” The state will submit an implementation plan to CMS that will describe, among other factors, network adequacy standards.³¹

There are some early state approaches. In **North Carolina**’s Healthy Opportunities Pilot Program, Network Leads develop networks of CBOs and abide by broad network efficiency and network adequacy standards. State staff also review these networks, and consider, among other factors, the degree to which networks include local organizations (versus national organizations with similar services), and how the network integrates organizations led by women or people of color. **California** requires plans to submit

quarterly implementation monitoring reports for HRSN initiatives (i.e., Community Supports and Enhanced Care Management) including, among other data, provider capacity.³²

States can work to pilot network sufficiency measures and establish baseline data. States can then determine whether to measure progress via a sufficiency goal, improvement, or other metrics. Holding HCOs accountable for these metrics too early could lead to unrealistic expectations that may be impossible to meet or force HCOs to contract with CBOs, regardless of quality, to build network capacity.

For example, states may adopt monitoring and oversight approaches used for home- and community-based services (HCBS) programs or managed long-term services and supports programs, which often feature HRSN services like benefit enrollment support, housing modifications, and home-delivered meals.³³ Many states may have recently invested in their HCBS programs and related HRSN infrastructure via their American Rescue Plan Act HCBS Spending Plans, and conducted related gap analyses.³⁴

Meeting the needs of Medicaid members in rural areas will be a challenge. In the short term, members can access some services telephonically, receive home delivery of some items like medically tailored meals, or be able to access non-medical transportation to the HRSN service. HRSN providers that travel to the home, like community health workers, may receive enhanced rates that reflect higher travel costs in rural areas.³⁵ In the long term, HCOs may be interested in expanding local service offerings and building new community spaces, like sobering centers.

- **Track use of HRSN services.** Early HRSN approaches may measure “touches” or “alternative encounters” to inform health center payment, or the receipt of an intervention after a need is identified, to inform quality measurement (i.e., a “closed loop”).^{36,37} In other cases, a summary of an HRSN intervention and impact may only be summarized in MCO reports on performance improvement projects or specialized community-based care management initiatives.³⁸ Elsewhere, community resource referral platforms and community information exchanges can identify the breadth and number of services provided to Medicaid members. For example, **North Carolina’s** NCCare360 platform can track the referral outcomes, and generate CBO invoices for the Healthy Opportunities Pilot program. MCOs manually translate each CBO invoice into a medical claim, to facilitate state monitoring and payment.

CMS will require states with HRSN-related in lieu of services and 1115 demonstrations to collect more robust claims and encounter data, which may be both a pain point and sustainability opportunity. For example, early experiences in California have demonstrated the potential benefits of third-party clearinghouses to reduce administrative burdens of CBOs.³⁹

CMS and state priorities will also make health equity analyses more commonplace. CMS’ in lieu of services guidance asks states to ensure that service utilization is stratified, when possible, by sexual orientation, gender identity, race, ethnicity, disability status, and language spoken to inform health equity initiatives and efforts to mitigate health disparities.⁴⁰ Section 1115 demonstration projects have similar health equity-focused expectations. For example, **California** plans to use performance metrics

and available data to address “access needs of communities that have been historically under-resourced because of economic or social marginalization due to race and ethnicity, urbanicity, and other factors.”⁴¹

4. Assess Impact on Health Outcomes and Disparities

Many HRSN services have a strong evidence base, and new Medicaid initiatives will lead to additional learnings. While these partnerships can support concrete opportunities to improve health care quality and lower health care costs, overreliance on short-term health outcomes and financial impacts can stymie long-term efforts. CBO-HCO partnerships are an important way to promote health equity, engage individuals who have been marginalized and earn their trust, and shift to person-centered care and measurement.⁴² As such, HRSN services may require different definitions of success, over a longer timeframe.



While this work is still new, states are identifying ways to measure the impact of CBO and HCO partnerships moving forward. For example, per recent federal guidance, some states will be required to — or in some circumstances may elect to — conduct a retrospective evaluation of in lieu of services that assesses, among other factors: cost-effectiveness, impact each service had on utilization of state plan-covered services or settings, and impact on health equity initiatives and efforts undertaken by the state to mitigate health disparities.⁴³ States with demonstration opportunities will be investigating whether expanding access to HRSN services “promote coverage and access to care, improve health outcomes, reduce disparities, and create long-term, cost effective alternatives or supplements to traditional medical services.”⁴⁴ Much of this work is to be defined, in state protocols and federal guidance. But health equity goals should be front and center as states develop, refine, and evaluate their initiatives.⁴⁵

Resources for Evaluation

The Social Interventions Research & Evaluation Network’s 2022 National Research Meeting, entitled “Racial Health Equity in Social Care,” showcased ways to connect HRSN research with health equity priorities. See [presentations](#) for helpful guidance to inform evaluation strategies.

Looking Ahead

CMS is asking state Medicaid programs to make transformative changes to the traditional model of health care by encouraging CBO-HCO partnerships. Despite increasing demands on the CBO sector from state agencies, state efforts to support and sustain CBO services and guidance for effective partnerships between CBOs and HCOs remain limited. While the early state approaches discussed in this report are useful examples as more states attempt this work, all the state programs explored are still in the very early implementation stages, and will likely continually rework and refine their initiatives. States will likely be embarking on new ways of co-designing and partnering with CBOs and community members to ensure these HRSN initiatives are high-quality, well-coordinated, and sustainable.

Appendix: Features of CBO-HCO Models in Select Leading-Edge States

STATE	NAME OF PROGRAM(S)	POPULATION SERVED	PROGRAM TIMELINE	WHO MANAGES CBO PARTNERSHIP?	CBO OVERSIGHT FEATURES
California	Enhanced Care Management and Community Supports	High-needs populations of focus, such as individuals experiencing homelessness, justice-involved populations, and pregnant people	Launched January 2022	Managed care plans (MCPs)	<p>State activities:</p> <ul style="list-style-type: none"> Developed the following materials: <ul style="list-style-type: none"> Standard Provider Terms and Conditions Model of care template (legacy) DHCS/MCP Contract Template Non-binding pricing guidance for Community Supports
Massachusetts	Community Partners, Flexible Services , and Community Support Programs	Populations with behavioral health (BH) and long-term services and supports (LTSS) needs ; Medicaid enrollees served by ACO providers; individuals experiencing homelessness, with justice involvement, or behavioral health needs facing eviction	Launched 2018; waiver extension request approved through December 2027	ACOs (all include organizations, some partner with MCOs) provider	<p>State activities:</p> <ul style="list-style-type: none"> Selected Community Partners, and provided them with DSRIP funds. Required ACOs to work with all state-approved BH and LTSS Community Partners to provide care management and care coordination for eligible enrollees, with some required elements for contracts. Developed metrics to monitor and track program performance in key domains. Proposed some network sufficiency requirements for new waiver (e.g., minimum # of Community Partners contracted). Did not require, but strongly encouraged, ACOs to contract with CBOs to provide flexible services; most ACOs do partner with a CBO for Flexible Services.

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STATE	NAME OF PROGRAM(S)	POPULATION SERVED	PROGRAM TIMELINE	WHO MANAGES CBO PARTNERSHIP?	CBO OVERSIGHT FEATURES
North Carolina	Healthy Opportunities Pilots (related 1115 demonstration described these services as “enhanced care management and other services”)	Medicaid patients with HRSN in defined regions	Launched March 2022	“Network Lead” a community organization that manages each regional Healthy Opportunity Pilot and creates a network of CBOs (“human services organizations”).	<p>State activities:</p> <ul style="list-style-type: none"> ● Procured and selected three Network Leads (formerly called “lead pilot entities”). ● Approved the applications and evaluation criteria Network Leads use to recruit CBOs/HCOs in their network. ● Required health plans to coordinate with all relevant Network Leads for their members. ● Developed model contracts (between health plans and network leads, and between network leads and CBOs). ● Provided a fee schedule for the 29 interventions provided by the pilots. ● Built CBO network “Adequacy” and “Sufficiency” into program (but no metrics yet) (see Network Lead RFP); considers size and diversity of CBOs in pilots.
New York	DSRIP Program	Medicaid patients in Performing Provider System area	Launched 2015; waiver renewal concept paper submitted	Previous demonstration included Performing Provider Systems, hospital-led networks that include CBOs; proposed demonstration will rely on MCOs, and create Health Equity Regional Organizations and Social Determinant of Health Networks.	<p>State activities:</p> <ul style="list-style-type: none"> ● Tracked DSRIP payments to CBOs. ● Created a high-level CBO guidance document. ● Proposed CBO networks in new waiver.

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Oregon	<p>Health-Related Services, Supporting Health for All through Reinvestment (SHARE), & In lieu of services [comparison here]</p> <p>New HRSN Services approved via an 1115 demonstration in 2022.</p>	<p>All Medicaid enrollees in the Coordinated Care Organization (CCO) region.</p> <p>New HRSN Services will be available to fee-for-service and CCO members.</p>	<p>CCO program launched 2012</p> <p>1115 renewal application approved through September, 2027</p>	<p>Coordinated Care Organizations (CCOs) (similar to MCOs)</p> <p>For new HRSN Services approved via an 1115, state will have a role, as it relates to provider enrollment.</p>	<p>State activities:</p> <ul style="list-style-type: none"> • Requires CCOs to spend a portion of net income/reserves on social services and equity (via the SHARE initiative), and approves related CCO spending plans. • Oregon Health Authority defined “Social Determinants of Health and Equity (SDOH-E) Partners,” and outlined requirements for CCOs around financial support (through SHARE and distribution of Quality Pool Earnings).

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