



Guidance for Health Care Entities Partnering with Community-Based Organizations

Addressing Health-Related Social Needs in Alternative Payment Models

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Executive Summary

This guidance document provides recommendations and examples of health policy and payment mechanisms utilized to address [health-related social needs \(HRSNs\)](#)ⁱ with a focus on collaboration between community-based organizationsⁱⁱ (CBOs) and health care entitiesⁱⁱⁱ involved in alternative payment model (APM) design and delivery.

Addressing HRSNs in partnership with CBOs is one important driver, among many others, in advancing health equity through APMs. Examples of other elements that warrant attention include improving access to quality health care, creating standard measurements and processes to ensure accountability, designing payment incentives that can shift resources towards caring for underserved individuals and communities, and facilitating authentic engagement and direct partnership with people who have been historically excluded from these efforts. This publication is one piece of a larger, long-term effort to address equitable health outcomes in payment reform. **The Health Care Payment Learning & Action Network (HCP-LAN) Health Equity Advisory Team (HEAT) is calling on health care entities to focus on and authentically engage the communities they serve in APM design and implementation—and to partner with CBOs to provide essential social benefits and services to patients through new and innovative care payment and delivery models.**

This document provides guidance for CBO engagement across four key themes. These themes, informed by interviews with CBOs and community care hubs, are generally geared towards health care entities except where the audience is explicitly noted. The high-level recommendations include:

Theme 1: Collaborative Governance Grounded in Mutual Respect and Shared Decision-Making

- ✓ Health care entities, with equal support from CBOs, consumer advocates, and community members—should collaborate to appoint an organizing body (e.g., a taskforce) that is rooted in the community to serve as a conduit for multi-directional engagement.
- ✓ Health care entities should develop processes (e.g., advisory groups) for formalized decision-making that incorporate the voices of community members at all stages of programming, from conceptualization to implementation and evaluation.
- ✓ Health plans should ensure that individuals hired for leadership positions (e.g., chief health equity officers) have previous experience working with CBOs.

Theme 2: Hubs and Neutral Conveners as Potential Conduits for Partnership

- ✓ Health care entities should consider partnering with an organization that takes on the role of an aggregator, convener, or facilitator for a network of CBOs that authentically represents the diverse communities the CBOs serve.
- ✓ Health care entities should involve and compensate CBOs, convening organizations, consumer advocates, and community members in the co-design and implementation of APMs.
- ✓ Health care entities should gain buy-in from CBO conveners (including hubs), by collaborating with them on community events that increase visibility and brand recognition.

Theme 3: Building CBO Capacity and Infrastructure through Multi-Sector Partnership

- ✓ Health care entities should offer technical assistance (TA) and resources for CBOs to develop the infrastructure needed to participate in APMs. Hubs, conveners, and larger CBOs play a critical role in providing TA and resources for CBOs and can offer these services at different levels depending on the existing capabilities of an individual CBO.

ⁱ This guidance document defines health-related social needs as “social needs like food insecurity and unstable housing that exacerbate poor health outcomes and quality of life. While social determinants of health are broader social conditions, HRSN are more immediate individual, or family needs impacted by those conditions.”

ⁱⁱ This guidance document defines community-based organizations as “a non-profit organization whose members represent a local community and focus on addressing the community’s sociocultural conditions and lived experiences. This can include improving the community members’ social and health risks.”

ⁱⁱⁱ Throughout this document, “Health Care Entity” refers to health plans, payers, providers, and purchasers (e.g., commercial health plans, employers CMS, State Medicaid Programs, Integrated Delivery Systems).

- ✓ Health care entities should provide CBOs and conveners with technology and access to relevant data (including social needs data), and support CBOs in utilizing data effectively for baseline and longitudinal performance measures.
- ✓ Health care entities should provide upfront funding to support technical assistance and resources.

Theme 4: Funding and Financing to Support Cross-Sectoral Collaboration to Address Social Needs

- ✓ Payers and health plans should advocate for and help organize CBOs, CBO conveners, consumer advocates, and community members to influence state Medicaid waiver development (especially 1115 waivers, but also 1915 waivers) to support cross-sectoral collaboration to address social needs.
- ✓ Health care entities should provide pre-funding support or infrastructure grants to help CBOs meet the necessary startup and operational needs to partner with the health system on providing social needs services, regardless of whether a particular states' Medicaid waivers currently can fund this.
- ✓ Payers and health plans should incorporate feedback from local health care purchasers and CBOs when developing plans for how to price and define CBO and CBO convenue services in their state within existing "in-lieu-of service" ILOS^{iv} authority.
- ✓ Health care entities involved in value-based programs should require portions of bonuses, budgets, or budget surpluses – at both the provider organization and plan levels – be spent on social needs services or equity, in collaboration with the community and CBOs.

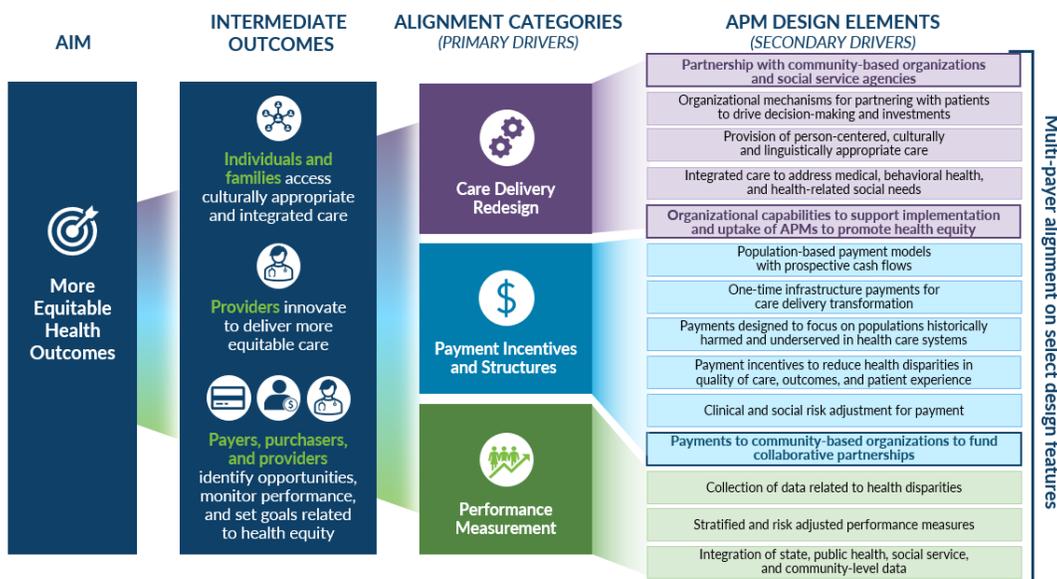
^{iv} ILOS allows health plans to pay for nonmedical services instead of standard Medicaid benefits when it is medically appropriate and cost effective to do so. Because ILOS is authorized under [federal Medicaid managed care regulations](#), no waiver is required.

Foreword

This year, the Health Equity Advisory Team (HEAT) focused its efforts on how health care entities can advance equity in APM design and implementation by partnering with CBOs that provide services addressing HRSNs for individuals, families, and their communities.

The HEAT’s [Theory of Change to Advance Health Equity through APMs](#) identifies three interrelated primary drivers for advancing health equity: *Care Delivery Redesign*, *Payment Incentives and Structures*, and *Performance Measurement*. Within these three alignment categories, there are 14 design elements or “secondary drivers”. This guidance focuses on three of these design elements: *Partnership with Community-Based Organizations and Social Service Agencies*, *Organizational Capabilities to Support Implementation and Uptake of APMs to promote Health Equity*, and *Payments to Community-Based Organizations to Fund Collaborative Partnerships* (depicted in Figure 1)

Figure 1. APMs that Address Health Equity Theory of Change



Ensuring that all individuals have an equal opportunity to address their medical needs and HRSNs and can thrive in the environments where they “live, learn, work, and play” are critical components of advancing health equity (The Centers for Disease Control and Prevention 2018). Direct engagement with individuals and communities is needed to truly understand their needs and lived experiences. Authentic engagement requires their participation in the development of solutions that directly impact them.

In addition to involving individuals and communities in this decision making, **multi-sector collaboration** (Figure 2) is necessary to design and implement APMs that advance health equity^v and integrate clinical care with community health and social services. With a renewed emphasis on advancing health equity through APMs, the publication of this guidance comes at a crucial time. While policies are changing, and there is some

Figure 2. Multi-Sector Collaboration in APMs



*Including commercial health plans, employers, CMS, state Medicaid programs, and integrated delivery systems

^v This guidance document defines health equity as “the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices— which includes systemic racism— and the elimination of health and health care inequities.”

funding to support CBOs in health care partnerships, the field is still evolving, with many challenges remaining and approaches emerging. Recent publications have highlighted CBOs as vital community partners, known for their trusted relationships and culturally congruent^{vi} services that address various HRSNs (Partnership to Align Social Care 2023; Schim and Doorenbos 2010).^{vii} CBOs are well-poised to make meaningful contributions in the continuum of value-based care (VBC), as supported by respondents of a recent HCP-LAN survey, where 55% of respondents rated referrals to CBOs as highly effective in addressing socioeconomic barriers, care coordination, and combatting health inequities (Health Care Payment Learning & Action Network 2021).

While there are [examples](#) of CBOs partnering with health entities to provide HRSN services, **the HEAT aims to provide multi-sector guidance to foster, build, and -sustain trust on a larger scale, reaching historically underserved individuals and enhancing health equity.** We are building upon emerging work to bridge knowledge gaps and offer practical approaches and examples for effectively including CBOs as meaningful and valued participants in APMs.

The HEAT strives to redefine collaboration and empower both CBOs and health care entities to advance health equity within APMs through a sense of shared ownership and collective action that is informed by community engagement (Center for Medicaid and Medicaid Services). While CBOs have a well-established history of direct community engagement, the HEAT acknowledges two related points. **First, the responsibility of engaging with individuals and communities should not solely fall on the shoulders of CBOs. Second, partnering with CBOs is not a substitute for direct community engagement, nor are CBOs entirely representative of the communities they serve.** While the scope of this guidance focuses more directly on the role of health care entities partnering with CBOs given their expanded role in new policy avenues, the HEAT emphasizes the need for continued consideration of the broader responsibility of fostering engagement with individuals and communities.

As the HEAT continues to focus its activities and dialogue on community engagement, the HEAT will emphasize and apply the following guiding principles to elevate the leadership and insights of individuals and communities with lived experiences.^{viii}

- **Understand and respect lived experiences** – Health care entities need to consider qualitative data and insights derived from first-hand experiences to effectively serve communities and individuals, specifically populations historically harmed and underserved.
- **Recognize the plurality of lived experiences** – There is no singular lived experience, and underserved populations and communities are not monolithic groups. An individual's experiences can be shaped by different experiences of marginalization based on different aspects of intersecting identities, and thus, is unique to that individual and not representative of all.
- **Respect the agency of individuals and communities** – Equity requires valuing an individual's dignity above all else, honoring the perspectives and strengths of those with lived experiences, and respecting their beliefs, preferences, and personal decisions for themselves and families to ensure they have what they need to achieve optimum health and wellbeing.
- **Engage the community early and often** – Real representation matters. To ensure their needs are met, it is essential to actively involve community members in every stage of planning and delivery.
- **Shift from “power over” to “power with”** – Empower and amplify the communities' voices to foster equal participation and leadership in decision-making and implementation and create infrastructure and accountability to do so.
- **Build on existing community assets** – Leverage and invest in organizations that are underfunded yet are already competent service providers trusted by communities to truly represent and meet their needs.

^{vi} This guidance document defines culturally congruent as a process of effective interaction between the provider and client levels. The model is based on the idea that cultural competence is ever evolving; providers must continue to improve their quality of communication, leading to improved quality of care.”

^{vii} Addressing HRSNs is important component of improving health equity, but one of many other components.

^{viii} Increasing representation of historically underserved communities and actively including them in decision-making will optimize how the health system's care is tailored to their lived experiences. The National Academy of Medicine's Conceptual Model for Assessing Community Engagement could be leveraged in the sustained commitment to this work.

Glossary of Terms

Accountable Care Organization (ACO): Groups of doctors, hospitals, and other health care providers who come together to spend health care dollars more wisely and deliver coordinated high-quality care to patients they serve (Center for Medicare & Medicaid Services).

Alternative Payment Model (APM): A payment approach that is “alternative” to fee-for-service and links payments to providing high-quality and cost-efficient care. APMs can apply to specific clinical conditions, care episodes, and patient population types. There is a spectrum of APMs, including advanced APMs that more strongly tie to accountability for quality and total cost of care for populations (Health Care Payment Learning & Action Network 2017).

Backbone Organization: A coordinating body that supports and coordinates a diversity of entities and streamlines the collective towards a shared goal. Backbone organizations can take the form of local public health departments, hospitals, foundations, etc. (Turner et al. 2012). In this document, we discuss backbone organizations in the context of those convening entities from the community, health sector, and social services sector.

Community-Based Organization (CBO): A non-profit organization whose members represent a local community and focus on addressing the community’s sociocultural conditions and lived experiences. This can include improving the community members’ social and health risks (Aideyan 2018).

Community Care Hub (CCH or hub): A community-focused body which serves to organize and support a network of community-based organizations that provide care and services to address health-related social needs (Administration for Community Living 2022).

Health Equity: The attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices—which includes systemic racism—and the elimination of health and health care inequities (Health Care Plan Learning Action Network 2022).

Health Care Entity: Throughout this document, “Health Care Entity” refers to health plans, payers, providers, and purchasers [e.g., commercial health plans, Centers for Medicare and Medicaid Services (CMS), state Medicaid programs, integrated delivery systems].

Health Related Social Needs (HRSNs): Social needs like food insecurity and unstable housing that exacerbate poor health outcomes and quality of life (Crumley and Bank 2023). While social determinants of health are broader social conditions, HRSN are more immediate individual, or family needs related to those conditions (National Diabetes Prevention Program Coverage Toolkit 2023).

Social Determinants of Health (SDOH): The social determinants of health are the conditions and environments in which people are born, live, learn, work, play, worship, and age. SDOH affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2030).

Value-Based Care (VBC): A health care delivery model that aims to promote equitable, high-quality, and cost-efficient care by basing health care providers’ earnings on patients’ quality of care and health outcomes (Lewis et al. 2023; NEJM Catalyst 2017).

Lived Experience: Knowledge based on someone’s perspective, personal identities, and history, beyond their professional or educational experience (Ramirez 2023).

Background

Over the past two decades, the health care system in the United States has been undergoing a transformational shift moving from a fee-for-service (FFS) delivery model, in which providers are reimbursed for the services or procedures delivered regardless of the individual’s health outcome, to a value-based care delivery system linking reimbursements to quality of care and measurable health outcomes (Montgomery 2018). APMs can be a vehicle to move towards VBC by aligning provider incentives with delivering high-quality, patient-centered care. While addressing inequities in health outcomes and advancing health equity could be foundational elements of VBC and APMs, APMs have historically lacked a direct focus on health equity (Center for Medicare & Medicaid Services Innovation Center). This appears to have resulted in the potential benefits of VBC not extending to those who most would benefit, and in some cases may have worsened health inequities (Horstman 2023).

In addition to the moral imperative of addressing inequities and driving towards VBC, the economic need for action is underscored by a recent [National Institutes of Health-funded study](#) finding that racial and ethnic health inequities cost the US economy approximately \$451 billion annually. A focus on health equity requires APMs and the health care partners that administer these models (e.g., Medicare, Medicaid, and commercial health plans) to acknowledge and address the unique health and social challenges individuals face. Beyond individual focus, health care partners have an opportunity to address the impact of structural and systemic barriers inherent to our health care system (Weissman et al. 2023). **Advancing health equity is becoming a key priority in APMs and therefore should be directly integrated into the design, implementation, and evaluation of innovative payment and delivery models.**

Health care entities that aim to provide person-centered care can expand their reach and understanding of social and health related risks by partnering with CBOs to provide health related services. **CBOs are entities with varying funding structures that serve a community or its segments, offering holistic, client-centered services through continuous engagement, often addressing HRSNs through direct service delivery or care management** (Aideyan 2018). According to the [National Academy of Medicine](#), clinical care accounts for only an estimated 10-20% of the modifiable factors that determine health outcomes, while social determinants of health (SDOH)^{ix} and HRSNs, which are often CBO priorities, account for roughly 80-90% (National Diabetes Prevention Program Coverage Toolkit 2023). While advancing equity in clinical care is absolutely needed and many partners are focused on this work, organizations focused on solely on that for patients with significant social risk factors^x are unlikely to see improvements in their health outcomes without support from community partners to help meet their social needs.

Involving CBOs as participants in payment models and including them in them design and implementation helps health care partners move closer to achieving VBC by addressing SDOH and HRSNs. However, partnerships between CBOs and health care entities are not without challenges. CBOs interviewed to inform this document expressed concern participating in APMs due to financial constraints, technological limitations, and operational challenges such as administrative capacity and limited resources to fully meet the needs of their communities. Complex historical power dynamics between the medical and social services field persist (Adebayo et al. 2018). Social service funding is lacking, partially driven by historical policies and structural racism, and worsened by recent market fluctuations

Benefits of Collaborative Partnership

Rebalancing resources towards the community and community partners, like CBOs, has the potential to advance health equity within VBC and APMs. This is especially true when partners invest in addressing HRSNs via CBO services that advance their shared goals. By way of these important partnerships, individuals and communities will experience increased agency over their health and social needs leading to improved health outcomes. Concurrently, health care partners will reduce traditional medical care expenditures by prioritizing the improvement of HRSNs to advance health equity.

In one example of innovative partnership, The Children's Law Center in Washington, DC teamed up with AmeriHealth Caritas (a large Medicaid managed care organization), to pilot a [pay-for-success program that aims to reduce asthma-related hospital visits by improving unsafe housing conditions.](#)



^{ix} While social determinants of health are broader social conditions, HRSN are more immediate individual, or family needs impacted by those conditions.

^x Factors beyond an individual’s health, such as employment, education, food accessibility, medical/legal partnerships, community literacy, geographic location, stress, discrimination, and transportation, influence health outcomes.

resulting from the COVID-19 pandemic (Tomasko et al. 2023). Power imbalances and persistent structural racism in many sectors, organizations, and communities must be examined and dismantled to allow for effective power sharing and governance. In addition to CBO-specific challenges, large health care entities also face their own set of obstacles when pursuing partnership. Challenges include administrative complexities, overhead and infrastructure costs, and supporting the development of partnerships (including facilitating contracts and relationship building) with CBOs providing HRSNs (Biedler 2023). These challenges should not be viewed as roadblocks for partnership, but rather, opportunities for valuable multi-sector collaboration and much needed capacity building to address health inequities.

This document provides guidance to health care entities involved in the design and implementation of APMs—and the participants through which they channel their APM investments—to establish, support, and sustain meaningful, bi-directional partnerships that value CBOs. It includes real-world examples throughout. This is only an initial step in the broader effort to address health equity both within and beyond the clinical setting.

Methodology

To ensure recommendations are community driven and informed by experiences, representatives from 11 CBOs and community care hubs (commonly referred to as “hubs”) participated in semi-structured qualitative interviews, and three additional representatives participated in a semi-structured panel discussion.

The interviews and panel discussion took place from May-September 2023 with the goal of better understanding CBO and hub priorities, challenges experienced in partnering with health care entities, lessons learned, promising approaches, and how they ensure the community voice is represented.

Various factors were considered in selecting organizations to interview including geographic region, populations served, organization size, and level of involvement in APMs (to ensure recommendations are representative of both CBOs that currently are and those that might not yet be engaged in VBC or APMs). Open-ended interview questions were developed to explore the necessary themes and provide an opportunity for participants to fully express their thoughts and perspectives. Feedback from participants was synthesized into four cross-cutting themes and further analyzed by HEAT members, subject matter experts, and the HEAT operator team.

Recommendations in the four thematic categories below are derived from interview findings and are part of a broader effort to provide guidance to health care entities to enhance collaboration with CBOs.



Theme 1

Collaborative Governance Grounded in Mutual Respect and Shared Decision-Making

Building collaborative, community-driven governance based on mutual respect between health care entities and CBOs is important to ensuring historically underserved and excluded populations have a role in deciding solutions that will directly impact them.

Setting a shared vision of collective impact and ensuring that CBOs, consumer advocates, and community members have a seat at the decision-making table contribute to trust-building and ensure mutual benefit. Historical reasons, such as lack of funding, systems of privilege and oppression, and institutional power imbalances, contribute to distrust of the health care sphere, which in turn makes bi-directional collaboration and communication challenging (Ahmed Mirza and Rooney 2018). When considering meaningful collaboration and power dynamics with CBOs, health care entities can reference the [Spectrum of Community Engagement to Ownership](#), an important interactive tool that charts a path to bring community partners forward from a place of marginalization and tokenization to community ownership.

CBOs face unique challenges as they operate across diverse sectors with varying funding streams (Strong Prosperous and Resilient Communities Challenge 2022). Interviewees noted that frequent leadership turnover, compounded by limited bandwidth and capacity of CBO workforce, makes it difficult for CBOs to keep pace with complex, and ever-changing demands of APM participation.

CBOs interviewed emphasized that program designs and implementations fail to consider ongoing issues related to stigma, biases, and a lack of understanding of people's lived experiences, as well as the benefits of direct engagement with community members.

Interviewees pointed to several promising strategies to promote collaborative, community-driven governance, and thereby ensure that community members themselves play a key role in conceptualizing, informing, and even correcting the policies and programs that directly impact their lives. For instance, CBOs noted that some existing forums directly engage with community members thereby bringing the diversity of individual voices into partnerships with health care entities and APMs (e.g., community advisory councils, regional health equity collaboratives, and one-off engagements including town halls, listening sessions, and community health needs assessments). Participants also highlighted that certain types of organizations that exist in most places, such as Federally Qualified Health Centers (FQHCs) and Primary Care Associations (PCAs) often have existing relationships with networks of social service organizations and CBOs serving similar populations and might be well suited to serve as a conduit for engagement between health care entities and CBOs (elaborated on in [Theme 2](#)). Additional promising strategies from the field are specified below, followed by HEAT recommendations.



Promising Strategies from the Field

The DC Primary Care Association (DC PCA), a backbone organization^{xi} for Washington DC-based community health and social service providers, health plans, and government agencies, engaged community members to serve as health ambassadors who conducted screening and outreach ([over 1,100 interviews](#)) in their neighborhood to persons experiencing homelessness, those at high-risk for [COVID](#), and other vulnerable populations throughout DC. By measuring and setting accountability goals on improving wellbeing, DC PCA was able to improve synergies between health care and other sectors, including [successfully advocating](#) for more funding to be directed towards services that DC residents reported affected their well-being and were more valued over health care coverage such as [housing](#) and [employment](#).

^{xi} This guidance document defines backbone organization as a coordinating body that supports and coordinates a diversity of entities and streamlines the collective towards a shared goal. Backbone organizations can take the form of local public health departments, hospitals, foundations, etc. In this document, we discuss backbone organizations in the context of those convening entities from the community, health sector, and social services sector.

- **Support and Services at Home (SASH®)**, developed by Cathedral Square (an affordable housing provider) is funded by the both the Vermont Department of Disabilities, Aging & Independent Living and OneCare Vermont (an ACO that participates in the Vermont All-Payer Model). SASH demonstrates how cross-collaboration among health plans, housing, and health care sectors can help minimize duplication of efforts. SASH coordinators, based at affordable housing sites, help to identify individual's HRSNs and medical needs, supporting more proactive coordination with community support services and health care providers participating in the ACO. Moreover, SASH has been independently documented to [reduce Medicare and Medicaid expenditures](#). The state's largest commercial insurer is entering into a formal agreement to have SASH support their higher need beneficiaries as well.
- **Volunteers of America (VOA)**, one of the nation's largest, faith-based comprehensive human services organizations, requires each of its site affiliates in 46 states, DC, and Puerto Rico, to have [community advisory groups](#) comprised of individuals reflecting the characteristics of the specific populations served. The community advisory groups have an intentional, human-centered design approach to ensure that the intended recipients of VOA services can provide input that is considered in the various initiatives at the inception of project planning efforts.
- **Oregon Health Authority (OHA)** requires their Medicaid [Coordinated Care Organizations](#) to each have a [community advisory council](#) (CAC). The CACs share lived experiences in accessing care within their communities and make recommendations to improve services. [CACs must be composed of at least 51 percent consumers](#) and must invite a tribal representative. There are [not yet comprehensive assessments of CACs](#), but there are [case study interviews](#) with illustrated examples of how CACs have influenced community reinvestment, dialogue about the health system, and wellness programs.
- **ACO REACH**, a Centers for Medicare and Medicaid Innovation (CMMI) Model, fosters collaboration by giving more influence to community members and beneficiaries within governing organizations. [CMS mandates that ACO REACH](#) governing bodies include at least one representative from the Medicare beneficiary group and another advocate for consumers. Furthermore, these individuals must possess [voting authority](#) within these governing bodies.
- **The Greater Flint Health Coalition** is a multisector partnership led by health care providers and partners and serves as a neutral convener to address health care needs and SDOH. The coalition was formed in response to General Motors attempting to reduce health care costs in the Flint community. Their health care providers decided they did not want a large corporation fixing their problems and came together to lead the community in discussions about what might work instead. Since the onset of the Coalition, community voice is at the heart of their organization with organizational leaders serving on board of directors and leading various taskforces since the onset of the Coalition.



Guidance and Recommendations

- ✓ **Health care entities, with equal support from CBOs, consumer advocates, and community members—should collaborate to appoint an organizing body (e.g., a taskforce) that is rooted in the community at the outset of partnership to serve as a conduit for multi-directional engagement.** These groups should be well-versed and experienced to (1) mitigate both explicit and implicit power dynamics that commonly underlie community-health care partnerships, (2) support alignment of language, terminology, and priorities of payers and CBOs, and (3) adequately and appropriately facilitate open dialogue between CBOs and the payer community as well as other health care entities such as providers and purchasers.
- ✓ **Health care entities should develop processes (e.g., advisory groups) for formalized decision making that incorporate the voices of community members at the decision-making table at all stages of programming, from conceptualization to implementation and evaluation.**
 - These community-focused decision-making processes must recognize the heterogeneity in lived experiences and allow for flexible modalities for community engagement, which can range from regular collection of feedback through town halls and surveys, to employing Community Health Workers (CHW) and Peer Recovery Specialists (PRS).

- While leveraging community members’ voices and lived experience is critical, be cognizant of repetitive touch points and develop processes to track engagement and document questions and feedback already shared. Incorporate feedback in decisions and design, and when feedback is not incorporated, explain why.
- ✓ **Health Plans should ensure that individuals hired for leadership positions (e.g., chief health equity officers) have previous experience working with CBOs.**
 - Ensure these officers have the appropriate resources to facilitate direct engagement with CBOs, consumer advocates, and community members and internally advocate for them when developing programs and policies that impact them.
 - Create positions with clear roles and responsibilities for establishing lines of communication to foster trust and equal partnership—and implementing community engagement activities such as outreach and consultation from individuals with lived experiences.



Theme 2

Hubs and Neutral Conveners as Potential Conduits for Partnership

In addition to balancing power dynamics, hubs and neutral convener organizations can offer broad infrastructure and administrative and technical support to under-resourced and under-staffed CBOs. Hubs can help connect health care entities to networks of CBOs to reduce contracting burden and bring community voice, SDOH, and HRSN service expertise.

Community care hubs or “hubs” are entities that have evolved over the past 15 years at state, local, and federal levels.^{xii} **Hubs can be defined as a community-focused body which serves to organize and support a network of community-based organizations that provide care and services to address health-related social needs.** Hubs collaborate with not just health care purchasers, payers, and providers, but also CBOs and community members to elevate the local voices and lived experiences of the community (Chappel 2022). More recently, hubs have gained traction in the federal space through a [new federal funding](#) and [learning community model](#) supported by the Centers for Disease Control and Prevention (CDC) and the Agency for Community Living (ACL) (Administration for Community Living 2022). Hubs are potentially **positioned to serve as neutral conveners of cross-sectoral organizations (including CBOs and FQHCs) to help balance power dynamics and build trust between historically siloed communities and health system entities.**

Most hubs have some sort of backbone organization – a coordinating body that supports and coordinates a group of diverse entities towards a shared goal – although as highlighted in “Promising Strategies from the Field” below, there are examples of hubs that have formed as a conglomerate of their members. Hubs can also potentially streamline [contracting efforts](#) by serving as single point of contact for both CBOs and health care entities. Further, for health care entities, hubs can help leverage the collective community voice and service expertise of the many CBOs within their network.

CBOs noted that the focus of a hub is influenced by the priorities and expertise of the backbone organization, which may not fully

Interviewees noted that hubs can potentially provide CBOs access to a broader network of support, thus reducing barriers, administrative complexities, and costs for CBOs participating in APMs. While hubs have promising potential, interview participants pointed to possible challenges. One challenge is that many health care entities and CBOs are unfamiliar with the hub model and its value proposition, making it difficult to gain buy in from key partners.

^{xii} “Community Care Hubs: Making Social Care Happen Background, Evolution, and Value Proposition of Working with a Local CBO Network Led by a Community Care Hub.” Partnership to Align Social Care: A National Learning & Action Network.

reflect the spectrum of needs or populations in the communities they serve. There are important reasons underlying this concern, including that some backbone organizations and their hubs arise to serve a particular subpopulation (e.g., hubs built on backbone organizations such as Area Agencies on Aging bring experience with older populations, but may need support expanding to work with CBOs and other subpopulations like children and working-aged individuals). CBOs suggested addressing these concerns by allowing flexible definitions of what constitutes a hub and ensuring diverse representation to reflect community voices. Participants voiced that hubs should not only involve representatives who provide direct services but should also include organizations who represent historically underserved populations. Additionally, to improve trust and impact on broader community subpopulations, hubs should leverage the [resources and tools provided by the CMS](#) on cultural and linguistic competency, provide hub partners with further training on cultural humility, and [consider capturing quality measures related to community experiences](#) of [provider communication and health literacy](#).

To gain legitimacy and support, some hubs interviewed have tapped into local health plans and health systems through intentional involvement of C-suite champions on their boards and by hosting celebratory community events to build brand recognition and community engagement. Hosting community events with CBOs and health partners also help to enhance partnership by allowing hubs and other health system event attendees to better understand the nuances of the CBOs in their region (e.g., charitable food assistance vs. medically tailored meal delivery).

[Hubs continue to evolve as key players](#) in reshaping the health care ecosystem. Alongside CBOs, hubs that authentically represent diverse communities with clear governance can also play active roles in co-designing APMs (e.g., helping to define networks and operations to address HRSNs, developing financing and investment strategies for sustainability of CBO participation).



Promising Strategies from the Field

- [DC PACT](#) is a community care hub convener for CBOs and the broader health system in the DC metropolitan community, with the DC Primary Care Association as its backbone organization. DC PACT's history of partnership building has allowed it to succeed as a trusted point of contact, and it works to coordinate resources across community and health sectors. In terms of a health system organization, interviewees noted that primary care associations could be positioned to be a hub or CBO "convener" due to their relationships with both more powerful health systems and more community-focused health care organizations like FQHCs.
- [Eliot](#) is a designated Behavioral Health Community Partner of Massachusetts' Medicaid ACOs. They are positioned as both a large CBO (providing housing case management supports and services through MA's 1115 waiver) and a backbone organization connecting ACOs to smaller community providers. Eliot's value proposition to ACOs lies in its expertise and network of community-based mental health services and connections with smaller, on-the-ground CBOs like local family resource centers and homeless shelters. They fill a referral need for ACOs by offering behavioral health services for people who may not have serious mental illness or require inpatient services, but still need more than just primary care. By contracting all community partners through Eliot, ACOs have access to a consolidated network of community partners while allowing Eliot to do boots-on-the-ground work and establish trust with the community. Eliot is an example of how a large and sophisticated CBO can also be positioned to serve as a hub.
- [Partnership to Align Social Care](#), a national learning and action network that includes CBOs, health plans, health systems, and federal agencies, works to develop streamlined contracting infrastructures between health systems, health plans, and CBOs, including building out the hub model.
- [Western NY Integrated Care Collaborative](#) is a hub that does not have a designated lead or backbone agency because they want everyone to have an equal say at the table. Their board is made up of leaders of all the founding organizations and CBOs, and they find it beneficial to not be bound by any legal or regulatory requirements of a particular backbone organization

- **Partners in Care Foundation** leads the **Partners at Home Network**, their network of CBOs (including Meals on Wheels, an array of aging and disability serving agencies, and many other specialty CBOs) across California that coordinate on social services. Partners in Care Foundation provides hospitals, ACOs, physician groups, and health plans with a single point of access to a coordinated community care system. Central to Partners’ early success was establishing an annual health care transformer award event to recognize entities who bridged sectors to transform care. This event brought together representatives from different sectors and allowed the network to brand themselves as a trusted source for community members.



Guidance and Recommendations

- ✓ **Health care entities should consider partnering with an organization that takes on the role of an aggregator, convener, or facilitator for a network of CBOs that authentically represents the diverse communities the CBOs serve.**
For example, community care hubs may help streamline APM partnerships between CBOs and health systems by acting as an intermediary that takes on administrative responsibilities for CBOs, while providing a single point of contact for payers to access a wide network of community-based resources. However, CBOs and other key parties have noted that community care hubs may not always accurately represent the interests and lived experiences of the community if there are not chances for CBOs, consumer advocates, and community members to have governing roles on hubs, and could potentially add new administrative burdens if not coupled with proper supports for CBOs.
 - To ensure that CBOs benefit from the partnership, payers should identify and organize aggregator, convener, or facilitator organizations (such as a hub) that are inclusive of the cultures and diverse lived experiences of the community. This means not only involving representatives who provide direct services, but also organizations who provide HRSN services addressing SDOH outside of the focus of the hub, and organizations who represent and advocate for historically underserved populations.
 - Increased funding to support these convener entities is needed from health care purchasers, including commercial insurers, state governments, and federal agencies (such as expanding the national Community Care Hub model).^{xiii}
 - The governance bodies of these aggregator and hub-type organizations should include significant representation of community members, community advocates, and CBOs.
- ✓ **Health care entities should involve and compensate CBOs, convening organizations, consumer advocates, and community members in the co-design and implementation of APMs,** including the decisions of SDOH service definitions, prices, and implementation. Hubs and conveners should also be allowed to develop their value proposition beyond the traditional definition of return on investment (ROI), to include a “social ROI” that accounts for the benefits of improving community well-being (rather than purely saved hospitalization costs). Health care entities should support efforts to define “social ROI” that build the financial case necessary to meet regulatory requirements (e.g., building out in-lieu-of-services, see [Theme 4](#) for more information). Demonstrating value related to SDOH outcomes can take time, which may not always align with payer timeframes. The short-term goal is to change care delivery to incorporate HRSNs, which are meaningful for individuals, and eventually move towards ROI in the long term.
- ✓ **Health care entities should gain buy-in from CBO conveners (including hubs), by collaborating with them on community events that increase visibility and brand recognition.** CBO conveners can enhance their credibility as valuable partners in care improvement by enlisting c-suite champions from local payers, health systems, and provider groups to serve on their boards. The prominence of CBO conveners can be further established by participating in public relations and community events in collaboration with local healthcare purchasers, which has proven to be an effective strategy in strengthening successful cross-sectoral initiatives, as suggested by existing literature (Bleser et al. 2022).

^{xiii} Note, there are entities (e.g., philanthropic organizations, other non-health related government agencies, etc.) that could potentially support these convening efforts.



Theme 3

Building CBO Capacity and Infrastructure through Multi-Sector Partnership

CBOs are often in need of additional staff, care coordinators, financing, workflows to manage referrals, technical assistance, and technology platforms with data transparency. Health care entities and neutral conveners have the potential to provide CBOs with much-needed resources.

While some CBOs already have the skills and [pre-existing infrastructures](#) to interact with health care entities, interview participants noted current legal, regulatory, and reporting requirements for participating in APMs are administratively challenging for many CBOs (Huber et al. 2023). For example, interviewees indicated that many CBOs do not have the legal counsel or health care compliance infrastructure to be compliant with health care and insurance regulations. CBOs operate in a hyper-competitive and historically under-resourced funding landscape often leading to financial challenges that hinder CBOs from developing necessary infrastructure.^{xiv} Upfront funding for CBOs and CBO conveners provided by health care partners seeking to contract with them is critical to building the infrastructure for health care partnerships and related competency development. While building infrastructure and funding are largely intertwined, financing is covered more explicitly in [Theme 4](#).

CBO Infrastructure

Interviewees noted that key elements of a successful infrastructure include care coordinators, financing, and workflows for CBOs to manage referrals, resource distribution, technical assistance, billing, and upgraded technology platforms with data transparency.

There are [many training](#) and [work-force development needs for CBOs](#), and interviewees specifically stressed the need for additional development in data sharing and infrastructure. There is poor interoperability among different electronic medical record systems and related difficulties in capturing and reporting data, especially related to SDOH. A recent [Health Affairs article](#) revealed that numerous accountable care organizations (ACOs) had insufficient data regarding their patients' social needs and the capabilities of potential community partners. Interviewees expressed frustration with managed care system partners having limited data sharing with CBOs and noted that this lack of transparency hinders meaningful shared quality improvement, cost reduction, and alignment on initial goals. Further, many CBOs interviewed do not have the technology or infrastructure for data analysis, or they are not provided with member-level data from health entities they partner with. There are limited examples of technology platforms that focus on sharing health and social needs data in one place, much less utilizing it effectively for reporting and performance measurement.

Some interviewees pointed to the hub model as having the potential to provide technical assistance and data infrastructure to help CBOs with billing, data storage, referrals, and other implementation supports to maximize CBOs' time focusing on communities they serve. Hubs can also serve as learning communities providing training and resources (e.g., a shared resource repository can offer contract and payment structure examples and templates). One data-related challenge CBO conveners and hubs are positioned to take on is around legal and regulatory compliance of data for cross-sectoral services (e.g., not just HIPAA, but [complying with regulations related to Homeless Management Information Systems or the Family Violence Prevention and Services Act](#), etc.). In the absence of a CBO network such as a hub, interviewees suggested that larger CBOs could potentially subcontract with smaller CBOs for service delivery. This concept both increases larger CBOs' reach while also creating more equitable opportunities for smaller CBOs to build partnerships with health care entities. Smaller CBOs can leverage larger CBOs' existing connections, share operating costs, and thereby avoid duplicative administrative and infrastructure costs.

^{xiv} There are many political, historical, and structural factors that explain why CBOs are largely under-resourced. For example, welfare reform in 1996 disenfranchised many and put immense pressure on CBOs to fill gaps in service provisions. Structural inequities, including systemic racism, have led to disparities in funding allocation for CBOs working with underserved communities (Tannenbaum and Reisch).



Promising Strategies from the Field

- [ACO REACH](#) is an example of a CMMI model requiring participants to provide beneficiary-supplied demographic data, encompassing information on race, ethnicity, gender identity, and sexual orientation. While reporting social determinants of health (SDOH) data using a validated assessment tool is optional for the first year, CMS strongly encourages model participants to do so.
- Medicaid plans such as [Inland Empire Health](#) and [certain Michigan plans](#) have incorporated payment incentives for providers to collect and exchange social data.
- [Washington DC's HIE](#) allows instant data sharing across providers, practices, and community-based organizations.
- [Volunteers of America](#) has a library of resources including model contracts, different payment structures, and examples of Community Health Worker (CHW) workloads which helps them when launching projects and pursuing partnerships.
- Community care hubs such as the [Partners at Home Network](#) and the [Western NY Integrated Care Collaborative](#) provide a comprehensive streamlined infrastructure that takes administrative burden off CBOs. The Partners at Home network manages the referral process, IT systems, workflows, and business development for their CBO network. The Western NY Integrated Care Collaborative allows their CBO partners to function without having their own billing systems or their own group National Provider Identifier (NPI) numbers, and they have centralized storage, and quality assurance programs.
- [211 San Diego](#) created cross-functioning teams to ensure that administrative and accounting staff can fuse different contractual and billing needs.
- [SASH](#) tried to mitigate data challenges by aligning their data platform with other systems—they first used Vermont's state system, and currently use [HUD's IWISH](#) model for their population health logistics data platform.



Guidance and Recommendations

- ✓ **Health care entities should offer technical assistance and resources for CBOs to develop the infrastructure needed to participate in APMS. Hubs, conveners, and larger CBOs play a critical role in providing TA and resources for CBOs and can offer those services at different levels depending on existing individual CBO capabilities.** Key infrastructural supports include:
 - Hubs and conveners supporting CBOs to develop the infrastructure needed to participate in APMS by both providing direct technical assistance and resources for CBOs, as well as creating a shared learning community that allows CBOs to share experiences and best practices with one another. These learning communities can also provide a shared resource repository, including examples of contracts, payment structures, and partnerships between health care entities and CBOs.
 - Community care hubs providing enhanced training and resources for newer or smaller CBOs on claims billing and referral technology and on cross-sectoral legal and regulatory compliance—and phase that funding out on a CBO level once certain skill levels are obtained.
 - Health care purchasers, including commercial insurers, state governments, and federal agencies, aligning on an approach to build CBO competencies based on the TA and resources e.g., participating in and supporting efforts like the Partnership to Align Social Care and cross-state learning collaboratives like the Community Care Hub National Learning Community (Administration for Community Living).
- ✓ **Health care entities should provide CBOs and conveners with technology and access to relevant data (including social needs data), and support CBOs in utilizing them effectively for baseline and longitudinal performance measures.**

- **Health care purchasers**, including commercial insurers, state governments, and federal agencies, should align on standardized SDOH data formats and platforms, screening tools, and CBO billing and referral processes (Crooke et al. 2021).
 - **State Medicaid Offices** could make partnership easier and data sharing more transparent through statewide Health Information Exchanges (HIEs), and potentially through integration of social needs platforms with HIEs.
- ✓ **Health care entities should provide up-front funding to support technical assistance and resources**; see [Theme 4](#) for details.



Theme 4

Funding and Financing to Support Cross-Sectoral Collaboration to Address Social Needs

Funding mechanisms are seldom developed with input from social needs service providers like CBOs or from community members. As a result, funding streams and reimbursement options for CBO services are often lacking, and when they are available, do not reflect the true costs of addressing social needs or providing the services desired by the community.

Whereas Theme 3 focuses on the opportunities for partners to assist CBOs with necessary infrastructure, capacity, technical assistance, and technology, this theme explores funding streams that would allow partners to provide these supports. There are several notable and continuously evolving health policy authorities for cross-sectoral financing opportunities beyond ad hoc funding (e.g., beyond philanthropy, grants, organizational investments, states, and local tax dollars):

- **Value-Based Payment models**, such as **ACOs or ACO-like entities**, are largely focused on population health. There is also a growing interest in integrating advanced primary care into accountable care models, exemplified by the CMS Making Care Primary model (Center for Medicare & Medicaid Services). In these programs, groups of providers take on financial risk for total cost and quality of care, either by sharing in savings or bearing losses relative to a predefined financial benchmark, or by working within a prospective budget. ACOs or ACO-like entities and corresponding contractual mechanisms exist in Medicare, state Medicaid programs (which can operate on either a fee-for-service or managed care basis), and commercial insurers. Shared savings bonuses offer flexibility in allocating funds for social needs services, without any specific requirements from the health purchaser or plan, although bonuses may be small, and savings are not guaranteed in FFS-based ACOs. However, health care purchasers, including commercial insurers, state governments, and federal agencies, can require coordination with CBOs on HRSNs. They may also require that portions of bonuses, budgets, or budget surpluses be allocated toward addressing HRSNs or equity-related initiatives.
- **Medicare Advantage authorities**. Prior to 2020, Medicare Advantage plans could only offer social services as “[supplemental benefits](#)” and count them toward their medical loss ratio as long as they offered them to all enrollees and are not paid for by Medicare. Beginning in 2020, through new [Special Supplemental Benefits for the Chronically Ill](#), plans could offer social needs services to certain chronically ill beneficiaries instead of all beneficiaries
- **Medicaid managed care authorities**.
 - **Managed care plan contracting strategies**. States can use [managed care procurement and contracting strategies](#) to directly incentivize cross-sectoral care coordination and address social needs. They can require managed plans to include CHWs in the care team or contract with CBOs

- with expertise in social needs services. [State-directed payments](#) are another mechanism to direct managed care organization (MCO) spending on HRSNs.
- **In-lieu-of services (ILOS).** Managed care plans can pay for social needs services as part of managed care rates “in lieu of” standard Medicaid benefits without waiver approval (Mann and Reyneri 2022). [Previous CMS guidance](#) specified that plans could only use ILOS without waiver approval if they could demonstrate the ILOS are cost-effective and medically appropriate. [2023 guidance](#) clarifies that ILOS can be preventive and indirect substitutes for existing benefits if they address advanced Medicaid objectives and there is precedent for approval in Medicaid.
 - **Value-added services.** Medicaid managed care plans can provide “[value-added](#)” social needs services not covered by ILOS or the state Medicaid plan. However, these services are not included in their capitated rates and plans generally must use their administrative dollars to fund them. However, value-added services can [sometimes](#) be counted in the numerator of the medical-loss ratio if they are considered to improve health care quality.
 - States can require VBP contracting strategies for Medicaid managed care organizations for all the services listed above. Many commercial insurers operating in Medicare Advantage, Medicaid, or commercial markets have operated through advanced APMs (Health Care Plan Learning Action Network 2020).
 - **[Section 1915 waivers.](#)** Through their State Plan, states can use 1915(c) and 1915(i) waivers to fund some social needs services for specific populations of seniors or people with disabilities. Social needs services through this authority can include home-delivered meals, non-medical transportation, vehicle accessibility adaptations, and supportive housing. More than half of states use capitated managed care to deliver these services (Medicaid and CHIP Payment and Access Commission).
 - **[Section 1115 demonstration waivers.](#)** With approval from CMS, states can receive substantial federal funding through Section 1115 demonstration waivers to test providing [social needs services](#) (Huber et al. 2023). These 1115 waivers allow for great flexibility in what is being paid for (e.g., offering more expansive definitions of social services to broader populations in Medicaid than Medicaid normally allows) and how services are delivered (e.g., substantially changing the delivery model to include CBOs and community care hub entities). States can receive new significant federal funding to pay for these services—although the demonstrations are time-limited (typically 5 years, though they can sometimes be renewed in altered form) and sometimes have expectations of [projected budgeted neutrality](#).

Many of these disparate funding authorities are new, with guidance evolving year-by-year; thus, the implementation of these financing mechanisms is a work-in-progress. Some interviewees expressed concern that the new ILOS guidance creates administrative and regulatory burden that is challenging for most CBOs. Interviewees voiced that these funding authorities often fail to provide financing for upfront or ongoing infrastructure and capacity-building costs (including for administrative, personnel, and technological costs needed to participate in these opportunities as highlighted in [Theme 3](#)). One area for future exploration is how marketplace plans can play a role. The federal and government, states, and commercial plans should investigate how individual marketplace plan eligibility can be expanded to individuals with HRSNs (and how to incentivize plan competition over benefits addressing HRSNs).

Interview participants noted that data and data technology present some of the largest financial and operational challenges when working across sectors to address social needs. This is a relatively new space with few technology platforms, significant gaps in social needs data necessary for implementation, and limited funding mechanisms to support capacity-building (Brousseau 2023).

Interviewees mentioned that many funding avenues, through Medicaid or otherwise, are affected by state laws and regulations which vary significantly on a state by-state-basis.

CBOs noted that funding mechanisms are seldom developed with input from social needs service providers or community members. Consequently, the available resources or rates for CBOs do not reflect the true costs of addressing HRSNs or the services desired by the community. Some interviewees mentioned that while value-based payment models like ACOs can provide flexibility to address social needs, it is typically optional, and most ACOs do not have a large enough patient population to justify funding CBOs to address social needs. Further, ACOs often care for large populations and many communities that do not share borders, which can make community engagement difficult at the ACO level.

This creates complexity for health care entities, hubs, and CBOs operating across state lines, necessitating the need for multi-stakeholder alignment while allowing flexibility to be responsive to local needs.

Compounding these challenges, many interviewees voiced concern regarding the limited guidance on how dollars allowed for addressing HRSNs can appropriately be passed on to CBOs. In other words, just because a health policy mechanism exists to fund addressing social needs does not mean CBOs will be involved and there is no guarantee that the funding will help CBOs leverage community linkages and knowledge of members' lived experiences. For example, many HRSN services in Medicare Advantage, Medicaid, or commercial plans come in the form of a "flex card" for beneficiaries to use on expenses related to food, transportation, gym memberships, etc. This approach does not leverage CBO's ability to teach the skills necessary to address many HRSNs or to navigate the complex social service system, placing that burden on individuals who experience a greater number of social risk factors.



Promising Strategies from the Field

- North Carolina Medicaid's 1115 demonstration program, [Healthy Opportunities Pilots](#), is perhaps the most expansive and direct example of addressing social needs in partnership with CBOs. Launching in early 2022, the Pilots authorized up to \$650 million to pay for four domains of services addressing food insecurity, housing insecurity, transportation, interpersonal violence, and toxic stress, in addition to other needs such as legal supports. The Pilots are being tested in three regions covering roughly one-third of the state. Each region is overseen by a "Network Lead" organization, similar to a community care hub, responsible for building and supporting networks of regional CBOs to deliver services. There are [29 specific services](#) across the social service domains in a fee schedule [designed with input from CBOs](#). The state's five Medicaid managed care organizations authorize payments and help identify eligible members for care managers to screen and enroll. Any standard Medicaid enrollee in one of the Pilots' regions must be screened for social needs and eligibility for the program, and if eligible, the social need must be addressed—it is not optional. The waiver budget includes up to \$100 million for capacity-building. A statewide cross-sectoral platform, NCCARE360, facilitates referrals and invoicing. Detailed [implementation and policy recommendations](#) from studying this program are available online.
- Three examples of commercial plans that have made significant donations CBOs and health systems through their respective foundations (with the goal of advancing health equity by addressing various HRSNs) include Blue Cross Blue Shield [Minnesota](#), [Massachusetts](#), and [Florida](#).
- The [District of Columbia's 1915i waiver](#) allows federal Medicaid dollars to be used for SDOH services. Specifically, beginning in Spring 2022, they launched a [Housing Supportive Services benefit](#) (housing navigation services and housing stabilization services), and are allowed to reinvest local funds into efforts to reduce homelessness. In DC's case, the housing supportive services are not part of Medicaid managed care organization's contracts, so DC Medicaid directly reimburses for services. Interviewees noted this source of money helped draw in CBOs.
- [California's Medicaid \(CalAIM\)](#) policy landscape takes multiple approaches to help fund and enable linkages between CBOs and health care centers. Many of California's Medicaid waivers—such as nursing home diversion, Home and Community-Based Services (HCBS) for medically complex patients, community care transitions, assisted living, and the recent waiver for justice-involved populations—have allowed public dollars to pay for community-based services. CBOs like [Meals on Wheels Orange County](#) are able to get Medicaid reimbursement for delivering nutritionally tailored meals because it's included as one of [California's 14 in-lieu-of-services](#).
- New Community-funded initiative to support HRSN's in Oregon: Building on many years of collaborative community efforts in Oregon to [address social determinants of health](#) through [Medicaid Coordinated Care Organizations](#), Oregon received approval in its 1115 waiver to officially offer HRSN benefits to specific populations (individuals experiencing life transitions, e.g., individuals who are homeless or at risk of homelessness). Approved HRSN services include things like short-term housing, housing support, nutrition education, and medically tailored food assistance. A pilot program developed by the [Health Share of Oregon Coordinated Care Organization](#) influenced the 1115 waiver application. The program's financing model involves collective commitment across regional partners allocating a portion of capitated payment towards provision of these benefits ([LAN 4c](#)), as well as direct capital contribution

- The HCP-LAN created the State Transformation Collaboratives (STC) to take a locally focused approach to address the needs of state populations through alternative health care payment. The STCs—Arkansas, California, Colorado, and North Carolina—are comprised of payers, with input from providers, health systems, purchasers, patient advocates, and community organizations. The [HCP-LAN Multi-Payer Alignment Blueprint](#) compiles successful multi-payer alignment initiatives from STC states along with national efforts and contributions from the LAN, and includes approaches and strategies to establish directional alignment in health equity.



Guidance and Recommendations

- ✓ **Payers and health plans should advocate for and help organize CBOs, CBO conveners, consumer advocates, and community members to influence state Medicaid waiver development (especially 1115 waivers, but also 1915 waivers) to support cross-sectoral collaboration to address social needs.** Section 1115 waivers can also be used to pay for upfront funds to help build infrastructure and capacity. Payers should advocate for and help organize CBOs, CBO conveners, consumer advocates, and community members to influence state Medicaid waiver development to achieve these goals, including making recommendations to CMS to help achieve change broader than the time limitations and scope of the waivers.
- ✓ **Health care entities should provide pre-funding support or infrastructure grants to help CBOs meet the necessary startup and operational needs to partner with the health system on providing social needs services, regardless of whether a particular states' Medicaid waivers currently can fund this.** Local health care purchasers and payers should also use their influence to bring local employers to the table to help fund similar collaborative efforts.
- ✓ **Payers and health plans should incorporate input from local health care purchasers and CBOs when developing plans for how to price and define CBO and CBO convener services in their state within existing ILOS^{xv} authority** and work those proposals through their state Medicaid so that they may be counted toward the medical expenditure portion of the medical loss ratio (MLR).^{xvi} There are some limited examples of this in practice (such as California's CalAIM), so establishing more widespread precedence will help influence broader change. This must include input from CBOs, CBO conveners, consumer advocates, and community members to try to capture the true costs of these services and map them through the ILOS process. While building out more real-world examples of this financing opportunity is important, one area for future exploration is how to do so through prospective payment tied to performance outcomes instead.
- ✓ **Health care entities involved in value-based programs should require portions of bonuses, budgets, or budget surpluses – at both the provider organization and plan levels– to be spent on social needs services or equity in collaboration with the community and CBOs.**

^{xv} ILOS allows health plans to pay for nonmedical services instead of standard Medicaid benefits when it is medically appropriate and cost effective to do so. Because ILOS is authorized under [federal Medicaid managed care regulations](#), no waiver is required.

^{xvi} This guidance document defines medical loss ratio as “a measure of the percentage of premium dollars that a health plan spends on medical claims and quality improvements, versus administrative costs.”

Proceeding with Purpose: Future Steps

Based on findings from this qualitative research, there are many opportunities for multi-sector collaboration in advancing health equity. One area includes broader research and discussion regarding the need for the development of performance standards and quality metrics to standardize accountability for collaborative partnership between health care entities and CBOs. Part of this work entails defining what it means to have a social “return on investment” (ROI) that incorporates the broader range of improved health, societal, and financial outcomes from meaningful interventions that address HRSNs for underserved individuals and communities.

Another area of importance is work pertaining to quality or accountability measures to be used for CBOs partnering with health care entities. This could supplement the “social ROI” work with development of potential measures around timelines for interventions, performance measures for contracting arrangements, and focusing on benefits that go beyond traditional health related outcomes. Standardizing how organizations collect and share SDOH data across different organizations are important components of measure development and key opportunities for partnership. While meeting social needs reaches far beyond the health care sector, more work is also needed to examine how providers (in addition to payers and purchasers) specifically work with CBOs and how clinical and social care intersect.

Additionally, health care entities and partners would benefit from developing a clear roadmap to better understand how funding flows from health care entities to community organizations to ensure CBOs are enabled to improve outcomes for the individuals and communities they serve. This work would involve considering how to direct and/or increase funding for convening and governance, monitoring, learning activities, and more.

When authentic multi-sector partnerships are realized, there is significant potential to accelerate progress in the health equity space and build sustainable and enduring engagement in the years to come.

A new [toolkit](#) by the Office of the National Coordinator for Health Information Technology (ONC) includes 11 foundational elements of SDOH information exchange such as mission and purpose, community readiness, and technical, finance, legal and policy considerations. These are approaches health care professionals can use to advance their unique SDOH information exchange goals.

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- Cathedral Square
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- DC Primary Care Association (DCPCA)
- HCP-LAN Operator Team
- Meals on Wheels of Orange County
- Partners in Care Foundation
- Partnership to Align Social Care
- Reinvestment Partners
- Southern Alabama Regional Council on Aging (SARCOA)
- Support and Services at Home (SASH)
- Volunteers of America (VOA)
- 211 San Diego

Appendix A: Additional Resources

In addition to the numerous recommendations and real-world examples offered in the guidance document, there are myriad useful existing tools and resources that CBOs and health care entities can leverage to advance partnership. This list is non-exhaustive, and there are many other organizations doing tremendous and important work in this space.

Partnership Resources

- [Value Proposition Tool: Articulating Value Within Community-Based and Health Care Organization Partnerships](#) assists partners in articulating their value within an emerging or existing partnership through a series of reflection questions and considerations (*The Center for Health Care Strategies*).
- [Integrating to Improve Health: Partnership Models between Community-Based and Health Care Organizations](#) outlines common approaches to aspects of partnership and establishes a framework to describe integration between community-based and health care organizations (*The Center for Health Care Strategies*).
- Designed for CBOs and HCOs in existing partnerships, [this tool](#) provides a format to understand progress toward benchmarks characteristic of effective partnerships, identify areas for further development, and guide strategic conversation (*The Center for Health Care Strategies*).
- This [reference guide](#) is intended to support organizations interested in building new or improving existing value-based payment arrangements. The guide highlights existing HCTTF resources and covers new ground regarding topic areas that organizations should consider when negotiating and operating VBP arrangements (*The Health Care Transformation Task Force*).
- These [six assessment tools](#) (Readiness Assessment, Network Readiness Assessment, External Market Analysis, Opportunity Assessment, Competitor Analysis, and Building the Business Case for Partnership) provide a starting ground for CBOs and health care entities looking to establish partnerships and assess their existing networks (*Aging and Disability Business Institute*).
- [This toolkit](#) represents Phase 1 of a multi-part, turnkey suite of resources to allow Medicaid managed care organizations to articulate the business case for launching, leading, or expanding initiatives focused on inequities and social determinants of health. The goal of this collective work is to equip Medicaid MCOs, state Medicaid agencies, and partners, including provider and community-based organizations, in taking meaningful steps forward in investing in social determinants of health to improve health equity (*Institute for Medicaid Innovation*).
- [Resource Guide Partnerships with Community-based Organizations: Opportunities for Health Plans to Create Value](#) (*Partnership to Align Social Care*).
- This [report](#) provides answers to the question of how to develop clinical-community partnerships and integrate care and services, with lessons from existing models and a step-by-step guide intended to offer guidance to those considering pursuing these partnerships (*Connecticut Health Foundation*).

Contracting and Finance Resources

- [Community-Based Organization and Health Care Partnership: What Does It Cost?](#) is an Excel-based tool to guide partnerships in estimating their total cost to help align goals, prioritize decisions, communicate with stakeholders, and advocate for funding (*The Center for Health Care Strategies*).
- [Building a CBO Network for Health Care Contracting: Choosing the Right Model](#) outlines types of CBO networks and includes examples contracting approaches and operational models used by these networks (*Aging and Disability Business Institute*).
- This [resource guide](#) explores many of the basic elements CBOs may encounter as they enter into contracting arrangements with health care providers and payers (*Aging and Disability Business Institute*).

- [Pricing CBO services in a new health care environment](#): offers CBOs interested in pursuing contracting opportunities with health care entities guidance on the development of competitive, performance-based pricing models (*Aging and Disability Business Institute*).
- The SCAN foundation offers [ROI calculators, budget and financial planning resources, pricing guides, and cost calculation tools](#) for organizations to better understand costs of services (*the SCAN Foundation*).

Hub Resources

- [Model Contracts for Community-Based Integrated Care Networks](#) offers examples of ways hubs can frame contractual relationships with their participating CBOs, with potential managed care payers and health providers (*Aging and Disability Business Institute*).
- [The Community Care Hub National Learning Community](#) brings together organizations serving as Community Care Hubs (CCHs) that are either in development, or interested in expansion to take part in, shared learning, information and resource sharing, and coordinated technical assistance with the goal of building the strength and preparedness of the CCH to address health-related social needs and public health needs through contracts with health care entities (*Administration for Community Living*).
- [State Supports for Community Care Hubs and Networks](#) shares examples of how states have supported the development of community care hubs (CCHs) and community care networks (CCNs) to better align health and social services in their state and address health-related social needs (HRSNs) (*Administration for Community Living*).
- [Community Care Hubs: Making Social Care Happen](#) offers a high-level overview of the background and evolution of Community Care Hubs; identifies existing operational CCHs among several well-known organizational models; and identifies research that demonstrates the value proposition for health care entities to work with CCHs in pursuing opportunities to align health care and social care systems. (*Partnership to Align Social Care*).
- [Working with Community Care Hubs to Address Social Drivers of Health: A Playbook for State Medicaid Agencies](#) identifies opportunities for state Medicaid agencies to partner with networks of community-based organizations and Community Care Hubs to address SDOH (*Partnership to Align Social Care*).

Additional HEAT Publications

- Advancing Health Equity Through APMs [Guidance on Social Risk Adjustment](#) (*HCP-LAN*)
- Advancing Health Equity Through APMs [Guidance for Equity Centered Design and Implementation](#) (*HCP-LAN*)

Appendix B: Health Equity Advisory Team Overview

About the Health Care Payment Learning & Action Network

The Health Care Payment Learning & Action Network (LAN) is an active group of public and private health care leaders dedicated to providing thought leadership, strategic direction, and ongoing support to accelerate our care system’s adoption of alternative payment models. The LAN mobilizes payers, purchasers, providers, patients, product manufacturers, policymakers, and others in a shared mission to lower care costs, improve patient experiences and outcomes, reduce the barriers to APM participation, and promote shared accountability.

Our Vision	Our Mission
The LAN will advance multi-stakeholder payment reforms to enable coordinated health care that achieves better health, equity, and affordability	Improved and equitable health outcomes, resulting in overall lower total cost of care

About the LAN Health Equity Advisory Team

The LAN established the HEAT to help identify and prioritize opportunities to advance health equity through APMs, to influence design principles and to inform LAN priorities and initiatives. Its goal is person-centered—leveraging APMs to help make needed care more accessible, drive better outcomes, and reduce inequities. Patient experiences, priorities, and perceptions are crucial elements the HEAT explores.

The LAN would like to thank HEAT Members and other partners for sharing their expertise and contributing to the development of this guidance document.

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