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"More than just checking the box": community-based organizations on their role in Medicaid redesigns

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Abstract

New York and Massachusetts 1115 Medicaid demonstration waivers aimed to prioritize social determinants of health and engage community-based organizations to improve health outcomes. This is an evaluation of community-based organizations' public comments regarding their participation in social services delivery within the 1115 waivers. Both states solicited public comments on waiver implementation to date and potential improvements. The research team extracted all publicly available comments ($n = 359$) made by direct service providers between November 2016 and April 2019. The sample was then limited to only comments that discussed social service provision and health care–social service partnerships ($n = 58$). Findings are presented in 2 stages: (1) concerns regarding delivery system reform incentive payments funding levels, timing, and flow and (2) perspectives on how states and Medicaid administrators could improve health care–community organization relationships. Resource-dependent, community-based organizations protested insufficient funding. Additional comments identified specific design, structure, and implementation aspects of the 1115 waiver that could improve partnerships. Despite 1115 waivers prioritizing social service integration, community-based organizations still feel underfunded and disenfranchised. Aligning with health care standards requires significant time and effort. Given resource constraints, the state must facilitate these investments. Community organizations' feedback can also offer guidance on waiver strategies in other states.

Lay summary

To address Medicaid enrollees' social needs, New York and Massachusetts have led the way in aiming to integrate community-based organizations into Medicaid policy and financing. In an evaluation examining public comments submitted by community-based organizations to state Medicaid offices, perspectives on participating in 1115 Medicaid demonstration waivers revealed 2 themes (1) financial concerns about funding, timing, and flow of payments and (2) nonfinancial suggestions for enhancing health care and community-based organization partnerships through standardized partnership standards, enhanced governance, and tailored metrics to better address social determinants of health.

Key words: Medicaid; social determinants; ACO; community organization; delivery systems transformation; 1115 waiver; public health partnerships; accountable care.

Introduction

Policymakers are increasingly recognizing the impact of social determinants of health (SDOH) on clinical outcomes and the well-being of vulnerable populations.[1-5] SDOH, defined as the environments and conditions in which individuals are born, grow, and work, are critically important in managing population health and achieving health equity.[6] This shift has reshaped health care strategies, with a renewed emphasis on addressing SDOH factors, such as housing instability or food insecurity. One such strategy includes health care entities partnering with social services organizations, especially focusing on Medicaid populations to better address patients' social circumstances. Given that Medicaid is a state insurance program serving low-income individuals and children, social needs are disproportionately prevalent among Medicaid beneficiaries, and addressing their social needs to achieve population health is critical. In several states, Medicaid managed-care models encourage these partnerships with community-based organizations (CBOs) to improve population health while lowering health care costs by prioritizing social factors.[7,8] Ongoing initiatives like Delivery System Reform Incentive Payments (DSRIP) programs and Centers for Medicare & Medicaid Services (CMS) Section 1115 Demonstration programs provide states with funding to support system transformation efforts. These mechanisms represent innovative policies aimed at transforming health care delivery, addressing disparities, and achieving fiscal responsibility within the Medicaid program.[9]

Section 1115 Medicaid demonstrations enable states to test health care delivery models distinct from federal program rules. These demonstrations undergo rigorous evaluation by CMS to ensure alignment with Medicaid goals, budget neutrality, and transparency requirements, among other criteria. DSRIP, a financing component of these demonstrations, fund innovative care delivery to Medicaid enrollees, while compelling health care entities and Medicaid offices to adhere

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to stringent quality metrics, ensuring the continuation of funding support and maintaining high-quality care standards.[10] Within this framework, and often while being funded through a DSRIP model, health care–community-based organization (-CBO) partnerships have focused on biometric outcomes (eg, blood pressure, diabetes control, etc) and cost reductions for "high need, high cost" patients,[11] aligning with health care delivery and insurer priorities.

Notably, states like New York (NY) and Massachusetts (MA) have taken steps in this direction by including language in their DSRIP and Medicaid 1115 demonstrations to encourage (MA) or require (NY) these partnerships. In MA's Medicaid redesign, a pivotal element was the mandate for all health care organizations serving eligible Medicaid enrollees to establish Accountable Care Organizations (ACOs). These ACOs not only provided health care services but were also required to screen for health-related social needs. They were encouraged to establish relationships with CBOs to address the identified social needs identified through screening efforts. Meanwhile, in NY, the DSRIP program focused on fostering collaboration among safety net providers to form regional networks known as Performing Provider Systems (PPS), each entrusted with the task of selecting projects that aligned with their specific regional needs and health care challenges. These policy changes have opened the door for joint delivery of social services by health care and CBOs, a departure from the traditional Medicaid framework. These distinct approaches reflect state-specific priorities, with MA's ACOs offering centralized coordination and NY's PPS providing regional flexibility (Appendix A).

Success, however, hinges on considering the experiences of all partners. An NY state DSRIP report has disclosed that many participating organizations observed positive impacts on patient care in connection with care delivery projects.[12] Past research has unveiled the enthusiasm of CBOs for partnering with health care[13] and has underscored the need for shared learning in cross-sector partnerships.[14] Yet, a gap remains in understanding CBO perspectives after the policies were enacted. Medicaid policies are suggesting, and in some cases mandating, health care delivery organizations to

Table 1. Comparing New York and Massachusetts DSRIP programs.

	New York	Massachusetts
Basic Medicaid		
Medicaid expansion?	Yes (applied 2014 and approved 2016)	Yes (applied 2016 and approved 2017)
Medicaid eligibility threshold	138% FPL	138% FPL
Policies and waivers		
Most recent 1115 waiver approval at data collection	December 2016	November 2016
Total number of Medicaid enrollees	5 678 417 (as of December 2016)	1 296 359 (as of November 2016)
Rounds of public comment solicited on current waiver	9 (May 2016 in NYC, July 2016 in Albany, August 2017 in Rensselaer, November 2017 in NYC, June 2018 in Albany, November 2018 in NYC, June 2019 in Albany, October 2019 in NYC + Syracuse)	2
Delivery System Reform Incentive Payments (DSRIP)	Yes	Yes
DSRIP length	2014–2020	2017–2022
Total DSRIP amount	$6.42 billion	$1.8 billion
Money available for CBOs	$1.5 billion (SDOH funds)	$1 billion (ACOs) $539 million (community partners[a]) $8 million (community service agencies) $115 million (statewide investments)
Current 1115 waiver start date	2014	2017
Current 1115 waiver expiration date	2022	2022
Waiver content/provisions		
Newly created risk-bearing health care entity	Performing Provider Systems (PPS)	ACOs
Emphasis on improving SDOH as a goal of the waiver	Yes	Yes
Required SDOH screening	No	Yes
Potential to use Medicaid dollars to pay CBOs	Yes (CHWs, disparities, education, food, housing, wellness)	Yes (focused primarily on health-related nutrition and housing)
Key funding program for CBOs	PPS (state requires PPS to form its own governing body including how to distribute DSRIP funds)	Flexible services
Financial contracts with CBOs required for value-based payment program	Yes	No
Role of CBOs	Part of PPS	Community service agencies

Abbreviations: ACO, Accountable Care Organization; CBO, community-based organization; CHW, community health worker; FPL, Federal Poverty Level; NYC, New York City; SDOH, social determinants of health.
[a]Community partners: community-based behavioral health and long-term services and supports organization.

Table 2. Organizational characteristics of community-based organizations that submitted reviewed comments.

	Percentage (total number of extracted comments) (100%; $n = 58$)
Sector	
Advocacy	36% (21)
Multiservice center	22% (13)
Food/nutrition	10% (6)
Housing	9% (5)
Behavioral health	3% (2)
Workforce development	2% (1)
Other	16% (9)
Community center	2% (1)
States	
Massachusetts	7% (4)
New York	93% (54)

cultivate collaborative relationships with CBOs, for the purposes of addressing SDOH. Health care leaders often participate in health care policymaking, but community organizations are not often at the table, missing the opportunity to provide valuable perspectives on policy impacts.[14] As Medicaid 1115 waivers were up for renewal, we aimed to answer the following research question: What are CBOs' perspectives of Medicaid redesigns that encourage and/or require partnerships between health care entities and CBOs? This paper aims to provide insights into the experiences of CBOs in response to these policy efforts. Drawing upon the experiences of NY and MA, 2 states with robust social service infrastructure, relatively generous Medicaid enrollment criteria, and similarly timed 1115 renewal applications, we analyzed publicly available comments to understand CBOs' perspectives and feedback on the 1115 waiver implementation's initial stage (Table 1). We present CBO perspectives and their concerns regarding the implementation of Medicaid waiver demonstrations, ensuring they receive due attention from Medicaid leadership. Our objective is to identify areas for process improvement, and amplify the voices of these critical, but often sidelined, partners. Through an exploration of CBO perspectives and their recommendations, this research contributes to a deeper understanding of the practical implications of policy shifts in the context of addressing SDOH.

Data and methods

During the 1115 Medicaid waiver resubmission, both NY and MA opened the public comment process using in-person meetings and written feedback to understand the initial implementation's effect on CBO partnerships with health care.[15]

We extracted all 359 publicly available comments submitted to respective states by CBOs on the pending renewals of the NY and MA Medicaid 1115 waiver between November 2016 and April 2019. This time frame encompassed the entire public comment period for the relevant waiver renewals. Comments included letters, emails, and transcripts of oral presentations at the public comment forums. A study team member downloaded all available comment submissions from state government websites.

Public comments were excluded if they were submitted by individual citizens (not on behalf of an organization), submitted by health care entities, or did not address our topic of interest (partnerships with health care entities). In instances where CBOs submitted comments closely resembling one another—most likely because they were from a template—only 1 of multiple comments was included in the dataset. Public comments were included from the following CBO sectors: advocacy ($n = 21$), multiservice center ($n = 13$), other (family services, rural community supports, etc) ($n = 9$), food/nutrition ($n = 6$), housing ($n = 5$), behavioral health ($n = 2$), workforce development ($n = 1$), and community centers ($n = 1$) (Table 2).

All included public comments ($n = 58$) were uploaded to Dedoose.[16] Primary source material was inductively coded for CBO feedback or suggestions for CBO–health care partnerships using a content analysis approach, which allows for analytic methods to be applied to source material not initially intended to serve as data.[17,18] This included identifying themes related to CBO characteristics, the forming of partnerships between CBOs and health care, partnership governance, metrics/outcomes, and partnership financing. Coding was harmonized across team members (D.T., C.A.S., J.M.G.) through independent coding and weekly meetings to review code applications. Codes were iteratively revised for clarity and specificity until the code sheet was finalized and applied to all remaining public comments. Coding discrepancies were resolved through consensus among the entire study team, ensuring complete agreement on all codes. Codes were then grouped into larger themes, describing CBO perspectives on health care partnerships, with particular attention on nonfinancial concerns and 1115 waiver renewal suggestions. This study was deemed non–human subjects research by the Tufts Medical Center Institutional Review Board (IRB).

This analysis only includes comments from 2 states, MA and NY, for specific reasons. First, both states were undergoing similarly timed renewals with robust CBO sectors, providing a unique opportunity to analyze CBO comments during a crucial policy evaluation phase. Structural similarities in how CBOs engage with health care entities through ACOs (in MA) and PPSs (in NY) allowed for meaningful comparisons, facilitating feedback into partnership dynamics. Last, both states' waivers promoted CBOs' collaboration with health care entities, providing a clear basis for examining shared policy objectives. While acknowledging sectoral differences within CBOs in Table 3, our analysis focuses on the collective CBO comments aligned with the broader policy objectives, making direct CBO-to-CBO comment comparisons beyond the scope of this paper.

Results

During our analysis, we noted a convergence of concerns among CBOs in NY and MA. These shared apprehensions underscore a harmonization of CBO feedback across these states, emphasizing the consistency of key themes in DSRIP partnerships. We present our findings in 2 stages. We first describe a set of CBO concerns regarding financial distribution under the waiver to fund their work (section A). We then describe CBO perspectives on enhancing health care–CBO relationships beyond funding considerations (section B). Representative quotes for each theme are provided in Table 3.

Financial reforms

The NY and MA CBOs both felt that Medicaid should continue to finance partnerships between CBOs and health care entities, but current investments were insufficient. The CBOs suggested that inadequate, or poorly designed, financial

Table 3. Illustrative quotes from community-based organization public comments.

Section	Theme	Quotations
A. Financial reforms	1. Time of funding	The current manner of contracting often demands that community-based organizations (CBOs) assume the risk in start-up and service provision with no guarantee that volume of referrals will realistically cover these costs.…Start-up costs and billing systems and training for the CBO should be included in the contract. (NY, multiservice sector, 2019)
		More time is needed to build the evidence base that will allow CBOs to prepare for the transition to VBP [Value Based Payment] and make the case for investment in these collaborative initiatives that address the Social Determinants of Health [SDOH]. NYS should commit additional time and resources to this end. (NY, other sector, 2019)
		The transition will result in significant financial risk for CBOs. Without financial support and technical assistance from the state, CBOs will struggle to adapt to a VBP system. Funding should be allocated to CBOs to meet the capacity and infrastructure needs associated with a VBP model, and should include advance payments or revolving loan fund to avoid cash flow issues. (NY, advocacy sector, 2016)
	2. Fund flow	CBOs should receive significant resources for the nonclinical services they are providing in support of the PPS projects. The Community-Based Organization Planning Grant was a positive step towards providing the support that CBOs need to negotiate fair rates with the PPSs. DSRIP [Delivery System Reform Incentive Payments] funds not allocated or fully spent by the PPSs should go to CBOs. (NY, advocacy sector, 2016)
		At present, hospitals could choose to refer out to [CBOs], most of which are nonprofits, [hospitals] reap the benefits of [CBO] services in achieving DSRIP goals and never reimburse for those services. On top of this, 95% of the incentive payments available must go to hospitals with only 5% to CBOs. In this scenario, because the services provided by [CBO] are not reimbursable under mainstream Medicaid, we could be overwhelmed by referrals that we have no resources to address. Other models, some made possible by the 1115 waiver, have this similar problem: Health Homes, Accountable Care Organizations (ACOs), Primary Care Medical Homes (PCMHs), etc (NY, food/nutrition sector, 2016)
		While funds flow delays affect all types of organizations participating in DSRIP, they are particularly harmful to smaller CBOs that need significant injections of funding to meaningfully fulfill their key roles as culturally competent links between the health care system and the underserved, underresourced, and/or isolated communities they serve. …. Until CBOs have a clear mandate with corresponding funding levels, the full potential of DSRIP remains untapped. (NY, advocacy sector, 2016)
	3. Level of funding	… [an] insufficient amount of resources was directed to community-based nonclinical providers, many of whom were providing key care coordination services but were poorly reimbursed for their work. CBOs struggled to gain an equal footing and recognition, …[and] many CBOs were poorly reimbursed for the services they delivered. (NY, housing sector, 2019)
		Going forward we recommend that each VBP contract should include a minimum percentage of Medicaid spend to be allocated towards Tier 1 CBOs. (NY, multiservice sector, 2019)
		CBOs cannot fully participate in Delivery System Reform Incentive Payments (DSRIP) without funding to increase their capacity to participate as full partners…. CBOs need to develop infrastructure to help them identify how they want to participate and up to now there has not been time/funding to do so. (NY, advocacy sector, 2016)
B. Nonfinancial reforms	1. Partnership standards	There is a risk of exclusion of valuable community-based social care providers in… communities…if the nucleus of the Value Driving Entities (VDE) is a Prospective Payment System (PPS) or gargantuan hospital system. For example, the smaller rural CBOs that are now engaged under the CBO Planning Grant were, in most cases, initially excluded from PPS projects. (NY, other sector, 2019)
		The present system provides no formal or official mechanism for CBOs to endgame with health care payers. Rather, CBOs list themselves in the state's directory and create a "value proposition" with the hopes that a health care partner emerges. For their part, Managed Care Organizations (MCOs)/health care providers are incentivized to approach their [Social Determinant of Health] requirement as a check-box: partnering with any Tier 1 CBO—with no minimum funding threshold—is sufficient to meet the requirement to participate in Value Based Payment contracting. (NY, advocacy sector, 2016)
		Some PPSs…have made concerted efforts to engage CBOs but overall what we hear from our members is that it's a struggle to participate meaningfully in this complex enterprise. In general, the overall DSRIP approach prioritizes the needs and desires of large hospital-centered systems and strategic supports are missing to enable CBOs to participate as full partners. (NY, advocacy sector, 2016)
	2. Restructuring governance	In the original implementation of DSRIP, innovation funds flowed from the hospital out to the community rather than the reverse, which resulted in delayed input on the structure of innovation by community-based organizations, who are experts in population health. Capacity building funding for the community to enable better care coordination and support unfounded services was also late to arrive and underfunded.…To remedy this issue, the new VDEs must have CBOs as a core part of the governance structure. (NY, multiservice sector, 2019)

(*continued*)

Table 3. Continued

Section	Theme	Quotations
		We believe that successful implementation [of] DSRIP will only be possible with the inclusion of CBOs from the initial stages of planning, designing, implementation, and evaluation. (NY, multiservice sector, 2019)
		However, [this waiver amendment] does not include a level of specificity needed to ascertain the intent and impact of the proposed changes. We ask that you make available more information on the estimated impact of these proposals in terms of number of people affected…as well as more details about how the changes will be implemented and administered. (MA, advocacy sector, 2017)
		We also urge the state to consider the potential for experienced lead CBOs to support these needs by serving as backbone CBOs for capacity building. Capacity development CBOs can serve as trusted brokers, forming coalitions of CBOs and fostering collaboration among them…lead CBOs can also ensure that CBO partners are able to participate in the complex regulatory environment, negotiate value-based payments, and tackle challenges such as data analysis and technology integration which often hinders partnership between clinical and community. (NY, other sector, 2019)
	3. Rethinking metrics and redefining value	Engagement of consumers and community representatives must be required in the DSRIP program extension. Consumer and community perspective should be incorporated into DSRIP by including people and representatives impacted by DSRIP in governance and oversight structures, by completing community needs assessments—done by agencies with proven experience working within communities in culturally competent ways—to ensure goals are appropriately identified, and by fostering consumer and community involvement through public forums and culturally-competent communications. (NY, advocacy sector, 2019)
		The program's goal was to improve students' educational outcomes, such as reductions in truancy and suspensions. Early data suggest that the participating schools have been more effective in resolving student crises and avoiding arrest and the student needing to leave school. It has also led to improvements in classroom learning environments and teacher morale. These types of important outcomes would not be easily captured in a value-based payment arrangement with an MCO. (NY, behavioral health sector, 2019)
		The DSRIP amendment request emphasizes community-level collaborations as an integral component of the success of DSRIP thus far, yet it invisibles the contributions of CBOs. The report emphasizes the need to recognize community health and social service providers in their role supporting the reduction of avoidable hospital use and other high-priority DSRIP measures, but fails to provide any analysis on the metrics associated with SDOH interventions spearheaded by CBOs. (NY, advocacy sector, 2019)

Abbreviations: MA, Massachusetts; NY, New York; NYS, New York State.

support from the state was the significant gap to meeting targeted metrics set by the waiver. The CBOs offered comments about funding in 3 domains: (1) timing of funding for CBOs, (2) design of fund flows between health care entities and CBOs, and (3) amount of funding available to CBOs.

Timing of funding

Community-based organizations suggested early and strategic funding from the state could reduce financial burdens that CBOs incurred as they prepared for Medicaid program participation. These burdens included administrative costs associated with contracting with health care entities and the state and the need for technical assistance. Specifically, CBOs needed funding to build infrastructure, upgrade IT (information technology) systems, and compensate CBOs for their time and involvement. Initial investment dollars from state Medicaid offices could allow CBOs to fully participate in designing and developing programs, plan to meet new administrative requirements, and have greater involvement in prospective payment systems. Sufficient start-up funding would enable CBOs to proactively engage with the state, health care entities, or third-party contractors to receive the implementation support and technical assistance necessary to establish bidirectional relationships with health care partners. Adequate initial funding would allow CBOs to develop and grow their programs based on their communities' needs, rather than being constrained by post hoc funding or reimbursements earmarked only for narrow-scope program implementation as is currently done, such as targeting patients with specific chronic illnesses or those identified as highest cost by health care entities. Early funding could also support CBOs during the planning process to enable their programs to be operational by the time that health care partners have identified target populations or chronic disease subgroups that they feel would benefit most from CBO involvement.

Building data-collection and financial management systems to reflect health care billing and payment models created another financial hurdle for CBOs at time of start-up. Whereas CBOs traditionally receive their funding primarily through grants, government contracts, or donations, new partnerships with health care entities under Medicaid demonstrations shifted to CBOs contracting with health care entities. The CBOs would only be reimbursed if they continued to meet quality measures or other predefined outcomes. According to public comments, these new systems required start-up funds to transition to new data-collection systems and to cover the costs for capacity, personnel, and technical assistance to meet these new targets.

Fund flow

Leaders of CBOs requested changes in how funds flow from state to health care entities to CBOs. According to public

comments, changing the flow of funds away from health system–mediated distribution would allow CBOs more autonomy in how to spend their money and more transparency surrounding how funds are allocated and are allowed to be spent. The CBOs suggested opportunities to improve the way in which funds flow from health care partnerships. For example, CBOs requested that all DSRIP dollars that were not spent by health care at the end of the period be reallocated to the CBOs. These unspent funds could prove meaningful to CBOs, which are typically severely resource constrained (Table 3). Another CBO highlighted that the renewal application of the waiver program should ensure that funding is equally distributed among stakeholders, including CBOs and local governments, to promote cross-sector collaboration.

The CBOs also requested more clarity and transparency on the timing and formulas for funds. During the waiver implementation period in NY, CBOs experienced funding delays with little information on why, when the funding would be available, or how the amount of funding would be calculated. They asked for clear language on the requirements of how funds flow to CBOs within the health care–CBO partnerships. The CBOs specifically asked for increased transparency on what proportion of funds are being spent by health care entities, the proportion of funds that are allocated to CBOs, and of funds that remain. Some CBO leaders expressed cynicism about how the lack of transparency in funding allowed health care entities to exploit CBOs but counted CBO successes towards their own state requirements. In so doing, health care entities were able to claim incentive payments while underpaying CBOs for the services that they provide. The CBOs indicated that the lack of clarity was particularly harmful for smaller organizations, which did not have sufficient capital or budgetary leeway to accommodate delays in funding.

Level of funding

Community-based organizations expressed frustration with the total amount of funding received to date. They expressed a need for sufficient reimbursement for the services they provided to maintain their social service programming. Lack of funding impedes their ability to improve and scale their services in their communities. One CBO mentioned that community-based nonclinical providers who were key to providing care coordination services were poorly reimbursed. Another CBO suggested including minimal levels of financing of Medicaid spending in each contract that a Tier 1 CBO had to enter to support their ongoing efforts. More funding would allow CBOs to invest more in their infrastructure and be readily available to collaborate with health care payers and partners. As 1 CBO noted, without defined spending guidelines on how CBOs will be properly resourced and supported to participate in the new payment models, the state only requires health care entities to "check the box" in their efforts to collaborate with CBOs.

Nonfinancial reforms

Community-based organizations in NY and MA reported organizational strains in their relationships with health care partners. Comments from CBOs indicated several areas that could be improved in future waivers to strengthen CBO–health care partnerships, including the following: (1) partnership standards set forth by state Medicaid offices, (2) governance, and (3) metrics and outcomes. Recommendations for state Medicaid offices in these areas included better regulation of CBO–health care partnerships, prioritizing CBO inclusion and input in partnership implementation decisions, and identifying metrics and outcomes for success that advance CBO values and long-term goals to more effectively address SDOH.

Partnership standards

Community-based organizations underscored the need for state-mandated standards governing collaborations between health care entities and CBOs. These standards should be implemented both at the initiation of a partnership and during the ongoing review of contracts between health care entities and CBOs. The CBOs identified an imbalance in the process of forming partnerships, with the perception that they must "pitch" themselves as potential partners to health care entities, often without adequate state resources or guidance to do so. The onus was on CBOs to initiate partnership with health care entities without the strategic support necessary to enable full participation, especially given the lack of cultural and structural change often needed to integrate them within this partnership (Table 3). The CBOs suggested that more assistance and counsel from the state at the start of the CBO–health care partnership would allow for a greater range of CBOs to develop a working relationship with health care entities.

From the CBOs' perspective, the creation of standards set forth by the state Medicaid offices would allow for CBOs and health care entities to draw from set expectations and establish best practices for their relationship. Standards would also enable more expansive collaboration between CBOs and health care, allowing for smaller and less established CBOs to meaningfully participate in the DSRIP process and incentivizing health care entities to collaborate with CBOs beyond simply "checking the box."

Suggestions included mandates for health care entities to collaborate with a spectrum of CBOs that range in size and services offered, rather than 1 large commercial CBO that may only provide 1 type of service or work with a particular patient population. Under the current waivers, health care providers were not required to refer patients for social services, but CBOs suggested that such referral for these services should be included in new iterations of DSRIP. Standards could also include minimum organizational support for CBOs, such as technical assistance and investment in IT infrastructure, to ensure sufficient organizational capacity for effective participation in partnerships.

Restructuring governance

Community-based organizations highlighted the importance of CBO representation at all stages in the decision-making processes to provide their expertise and input in Medicaid-led reforms. The CBOs expressed 2 modes of thought on how to best execute this: CBOs should have greater inclusion in existing Medicaid governance structures. CBOs emphasized the importance of the state including them at all levels of DSRIP planning, design, and implementation to ensure that their perspectives are not overlooked when critical decisions are made. Comments highlighted how exclusion from processes caused significant delays in program enrollment and initiation, ultimately resulting in funding constraints. Increased inclusion in decision making at the beginning of the waiver implementation would provide CBOs with the opportunity to offer realistic time frames, anticipate and address potential

implementation issues, and propose other social programs that may further the stated waiver goals but may be outside the purview of health care entities. From the CBOs' perspective, increasing the opportunities for their meaningful participation would allow for innovation beyond what health care alone could design.

Another suggestion by CBOs was the creation of more independent governance structures. Rather than being treated as an extension of health care entities, some CBOs proposed the development of an independent network that gives them full autonomy over applications for funding under DSRIP and process-level decisions. They noted that such an arrangement would make for a more equal partnership with health care entities, which would address the inherent imbalance of these partnerships. Creating CBO-specific governance structures would more explicitly honor their expertise in providing social services over decades. This would also promote diverse CBO inclusion, refined delivery of social services that address SDOH, and increased CBO autonomy in shaping DSRIP projects with health care.

Rethinking metrics and redefining value

Community-based organizations noted that metrics for quantifying success under the DSRIP waivers are focused on short-term health care–related outcomes. Community-based organizations can provide services that directly or indirectly impact health care outcomes, but the degree to which these services can be directly linked to health care–related measures varies depending on the CBO sector. The CBOs commented that the state, and value-driven entities that work with CBOs, should take into consideration the long-term and indirect impact of CBO-provided services on communities and on SDOH when developing metrics for success under Medicaid 1115 waivers. The CBOs perceived the state to be undervaluing the work done by CBOs, which have expertise in addressing issues beyond the traditional reach of clinical care delivery. The CBOs noted that the overarching goal of improved physical, emotional, and economic well-being for the individuals and communities they serve should be considered inherently valuable, and measures linked to DSRIP should strive to capture this value.

The CBOs proposed integration of Value-Based Payment outcomes developed in collaboration with CBOs and community members. In their view, new outcomes should include impacts on SDOH and racial equity to adequately capture the contributions of CBOs beyond health care–defined metrics. One such proposal for establishing these measures is the development of a community "needs assessment," or creation of a set of measures, that is completed at the outset of a CBO–health care partnership and used to continually evaluate the success of DSRIP programs in addressing the needs of the community, not just the priorities of the health care system. There was strong support for the utilization of independent evaluators in partnership with community members to identify potential measures and implement those measures for evaluation by the state. The CBOs commented that such measures should also prioritize populations with the most significant need and experiencing the largest health disparities.

Discussion

Our findings reveal significant opportunities for change, as CBOs remain optimistic and willing partners in the 1115 Medicaid waiver program. Financial considerations are central to forming and maintaining new partnerships, particularly among entities of diverse budgetary scope and size. Policymakers in NY and MA should recognize the need for adequate financial support to help CBOs fulfill their role in bridging the gap between the waiver's SDOH goals and the implementation processes. Community-based organizations need early investments to develop administrative infrastructure and prepare for program delivery scaling. They require flexible and reliable funding streams to ensure continuity, encourage innovation, and achieve programmatic goals.

Beyond financial concerns, CBOs offered instructive comments on specific design, structure, and implementation aspects of the 1115 waiver and DSRIP programs. Standardizing contracts between CBOs and health care entities could ensure diverse representation and opportunities for CBOs of different sizes and sectors to participate in the waiver referral and payment system. Reforming governance structures to be more inclusive of CBOs or establishing an independent CBO-led structure to manage Medicaid funding and reform under the waiver could maximize CBO contributions and value to patients. Finally, CBOs emphasize that unless health care goals closely align with their own, the true value and expertise in addressing SDOH will remain underappreciated and underutilized.

Our analysis highlights an inherent imbalance, with CBOs expressing skepticism regarding health care partners' willingness to engage in meaningful collaboration. Many health care partners seem eager to fulfill Medicaid waiver stipulations through simple referrals to large, established CBOs, yet such partnerships may not effectively promote multisector collaboration or improve population health outcomes. Health care entities' priorities are central to waiver design and implementation, such that CBOs feel devalued as potential collaborators, despite growing evidence that CBOs are critical to the success of larger population health initiatives.[19] The comments by CBOs suggest that, if funding is a measure by which value can be approximated, it is clear that health care does not value their CBO partners, evident in reduced compensation and insufficient prioritization in revenue streams. Policymakers and health care partners must acknowledge the need for sufficient funding and time for CBOs to meaningfully participate in DSRIP reporting requirements. These sentiments were consistent among CBOs in both MA and NY, demonstrating the congruence in CBO feedback on this partnership structure across these states.

The question remains whether Medicaid, a health insurance program, remains the most appropriate platform for brokering such partnerships.[20] As health care's goals continue to dominate partnerships, the relationship between health care and community entities may remain imbalanced, with funding and resource disparities posing further challenges. Maintaining a health care-centric approach risks medicalizing the work of CBOs by steering them towards adoption of health care infrastructure. The risks of this strategy include misinterpreting social needs as medical issues, diverting attention from addressing root causes of health disparities; shifting authority from CBOs to health care entities endorses a narrow perspective that fails to address the broader structural factors contributing to health inequities and restricting the range of interventions for enhancing population health.

Public comments emerge as a valuable source of CBO perspectives, offering rare opportunities for community engagement

and stakeholder input. State Medicaid offices may wish to expend greater effort to solicit such feedback from community partners in future iterations of waiver development, and further consider how they might hold themselves accountable for being responsive to comments.

Limitations

Several limitations warrant acknowledgement. It is crucial to highlight the lower volume of public comments from MA, attributed to the state's limited solicitation periods (2 in MA vs 9 in NY) (Table 1). Additionally, some CBOs from MA opted for collaborative feedback through advocacy groups, resulting in a unified voice but fewer individual comments. Experiences of CBOs in other states may vary due to sector-specific differences and partnership expectations. Our analysis primarily represents participating CBO perspectives, potentially excluding smaller or underresourced CBOs. Those CBOs disinterested in health care partnerships or DSRIP may not have contributed feedback.

Conclusion

Massachusetts and New York are invested in strengthening the collaboration between health care and community-based organizations to deliver social services. Comments from CBOs that have had experience in Medicaid-facilitated partnerships provided insight into opportunities, strategies, and incentives to improve this integration. The CBOs highlighted areas for improvement beyond financial considerations, signaling that they remain willing partners but need a seat at the table to ensure their value and expertise are recognized by policymakers. As experts in serving marginalized populations, CBOs play a critical role in improving access to health and social service programs at a time when there are increased demands for such services. Future research should determine best practices for CBOs to be included in the design and implementation of funding and process-level decisions to better align health care and social care.

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Supplementary material

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Conflicts of interest

Please see ICMJE form(s) for author conflicts of interest. These have been provided as supplementary materials.

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Human rights

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments or comparable ethical standards. This study was approved by the Tufts Medical Center Institutional Review Board.

Informed consent

This article does not contain any studies with human subjects performed by any of the authors.

Welfare of animals

This article does not contain any studies with animals performed by any of the authors.

Notes

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