Achieving Health Equity and Wellness for Medicaid Populations: A Case Study of Community-Based Organization (CBO) Engagement in the Delivery System Reform Incentive Payment (DSRIP) Program

AcademyHealth in partnership with Health Management Associates (HMA) and the Disability Policy Consortium (DPC)

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The Disability Policy Consortium (DPC) is a cross-disability advocacy and research organization whose mission is to advance the civil rights of all people with disabilities.

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Executive Summary

Achieving health equity and wellness for Medicaid populations requires meaningful partnerships between Community-Based Organizations (CBOs) and Health Care Organizations (HCOs).

The purpose of this issue brief is to showcase the vital role that CBOs can play in advancing health equity and wellness for individuals and communities in delivery system reform. This issue brief highlights current and potential barriers to positive collaboration between CBOs and Health Care Organizations (HCOs), from the vantage point of New York (NY) and Massachusetts (MA) CBOs operating in the context of their respective state Delivery System Reform Incentive Payment (DSRIP) programs. Both states are in the process of implementing DSRIP programs to reform their Medicaid care delivery systems.[1]

This issue brief presents five key lessons from New York City (NYC) CBOs seeking engagement under NY's DSRIP program. These lessons were developed by The Arthur Ashe Institute of Urban Health (AAIUH), the lead organizer of Communities Together for Health Equity (CTHE).[2] CTHE represents over 70 CBOs in New York City. Each lesson presented is then followed by reactions of CBOs in Massachusetts.

Taken together, the key lessons and reactions from CBOs form an important case study about CBO understanding of Medicaid reform and their potential engagement in these efforts. The issue brief also creates a compelling case for elevating the role of CBOs in the health care delivery system.

The five key lessons are:

- **LESSON 1. Delivery System Reform Must Be Rooted in Health Equity and Wellness Goals.** Working for health equity requires cross sector interventions at the community level. Beyond housing, education, and safety, efforts to achieve health equity must address racism and resulting racial disparities that ensue in the form of health inequities. Without a commitment to health equity and wellness, efforts to reform the health care delivery system will achieve only limited success.
- **LESSON 2. Bridging the Cultural Gap Between Health Care Organizations (HCOs) and Community-Based Organizations (CBOs) Requires a Paradigm Shift.** NYC CBOs found that many HCOs had not taken SDOH factors into consideration and were not aware of the contributions CBOs can offer.
- **LESSON 3. Successful Reform Requires Engagement and Expertise from Community-Based Organizations that Represent Their Communities.** CBOs believe that successful reform is tied to having a "seat at the table" and being fully engaged as equal partners in delivery reform.
- **LESSON 4. Community-Based Organizations Must Build Capacity to Level the Playing Field.** Building capacity is critical for CBOs to level the playing field between CBOs and HCOs.
- **LESSON 5. Community-Based Organizations Must Come Together as a Collective to Participate in Delivery Reform.** CBOs need a network for coordinating CBO planning for engagement in health reform.

We hope these lessons will generate discourse at all levels of the health care delivery system and lead to the development of a *National Blueprint for Advancing Health Equity Through Community-Based Organizations* to facilitate greater cross-sector collaboration between CBOs and HCOs.

The information presented in this issue brief is relevant to a broad audience including federal and state Medicaid policy makers and program administrators, CBOs, HCOs, Accountable Care Organizations (ACOs), health plans, advocates, and members of the community working hard to remove barriers to advance health equity and wellness for Medicaid populations.

BOX 1. WHY FOCUS ON MASSACHUSETTS AND NEW YORK?

The authors focused this issue brief around CBOs seeking engagement in DSRIP programs in Massachusetts and New York for three important reasons. First, both Massachusetts and New York have DSRIP programs. DSRIP programs can provide the perfect venue or catalyst for the development of meaningful partnerships between CBOs and HCOs around DSRIP outcomes. Second, New York's DSRIP program is an important resource for the ongoing development of DSRIP in Massachusetts. New York is in its fourth year of implementing its DSRIP program, while Massachusetts is in its second year of statewide implementation. NYC led CBOs have a mature experience base upon which to draw. Finally, the authors are experienced in both states. Heidi Arthur has led consulting teams supporting the development of both CTHE and a second CBO collective, the Hudson Valley Collective for Community Wellness, comprised of 23 CBOs serving the 7 counties north of NYC. Ellen Breslin has focused her work around improving payment and care delivery for Medicaid populations at the federal and at the state levels for three decades. This includes working at MassHealth in her home state of Massachusetts and as a consultant in New York. In partnership with colleagues from Minnesota, DPC and HMA, Ellen developed a framework and conducted a large-scale analysis of health disparities in Medicaid populations. Dennis Heaphy is a health justice advocate and policy analyst who works on reforming the care delivery system at the state and national levels. Dennis serves in leadership positions on several committees in Massachusetts and on several national committees to advance health equity for complex populations.

The authors share a strong commitment to advancing health equity and a deep respect for the role that Medicaid plays in our society.

Introduction

The purpose of this issue brief is to showcase the vital role that Community-Based Organizations (CBOs) can play in delivery system reform to advance health equity and wellness for individuals and communities.[10] This issue brief highlights current and potential barriers to positive collaboration between CBOs and Health Care Organizations (HCOs). Drawing on information obtained directly from CBOs, this issue brief is also intended to expand our collective understanding of CBO culture(s).

Why focus on CBOs?

It is widely recognized that Social Determinants of Health (SDOH) have a significant impact on mortality and morbidity.[3] CBOs can play a major role in addressing SDOH factors that drive health disparities and poor health outcomes. As well, CBOs are directly connected with the populations they serve, providing opportunities for cross sector relationships with HCOs in order to improve outreach and engagement in care.[4] CBOs commonly address an array of overlapping clinical and social service needs and can also offer critical wellness interventions to high-risk groups. The literature reveals examples of successful cross-sector collaborations between CBOs and HCOs.[5] However, CBOs still face many challenges in creating meaningful partnerships with HCOs.

What is the unique value of CBOs?

CBOs have a unique role to play in promoting health equity and wellness at the individual and at the community level. CBOs can play a pivotal role in assisting HCOs to reduce the cost and burden on hospitals by diverting emergency department visits and rehospitalizations.[6] Reducing avoidable hospital use by 25 percent reduction over five years is a central goal of NY's Delivery System Reform Incentive Payment (DSRIP) program.

CBOs are positioned to take on these unique and pivotal roles for many reasons, including:

- **Cultural affinity**. CBO leaders and staff often speak the languages and reflect the cultures of the populations in the community they serve. This is of particular significance when working with immigrant populations.[7]
- **Unique positioning**. CBOs can situate person-centered care within the context of the person's lived experience. They are often able to respond to "what matters most" to individuals, beyond their immediate and presenting medical needs.
- **Broad capacity**. CBOs can take on the full range of activities, support population health goals, advance health equity and wellness, and reduce health disparities. These are CBO roles that also assist HCOs in reducing the cost and burden on hospitals by averting emergency department visits and re-hospitalizations.[8]

This issue brief is structured around a presentation of the challenges facing CBOs participating in the DSRIP programs in New York City (NYC) as they seek engagement under the state's DSRIP program. These challenges are presented in the form of five key lessons. These five lessons were developed by Communities Together for Health Equity (CTHE), a coalition of over 70 small CBOs in NYC convened to improve CBO engagement in the state's delivery reform and to advance the transformation of the health care delivery system.[9]

This issue brief also presents the reactions of a broad cross-section of CBOs in Massachusetts (MA) to the five key lessons. The authors gathered these reactions from MA CBOs invited to attend listening sessions in Boston and in Worcester during the summer of 2018.

BOX 2. THE SOCIAL DETERMINANTS OF HEALTH

The Social Determinants of Health (SDOH), which include a range of economic, social and environmental factors, play a significant role in driving health outcomes. Many individuals covered under state Medicaid programs are adversely affected by various SDOH factors, including poverty, poor access to heathy food, lack of affordable and safe housing, and transportation barriers. Addressing these factors is critical to health outcomes. Source: Henry J. Kaiser Family Foundation.

BOX 3. COMMUNITIES TOGETHER FOR HEALTH EQUITY (CTHE)

In 2016, New York City's small, non-profit community-based social and human services organizations advocated for, and were granted, $2.5 million New York State (NYS) Community Based Organization (CBO) Planning Grants from the NYS Department of Health. The grants were intended to support the development of CBO consortia able to build CBO readiness for partnerships with Health Care Organizations (HCO), develop infrastructure for collective CBO planning, and complete strategic plans to facilitate CBO engagement in the transformed care delivery system. Called Communities Together for Health Equity (CTHE) and led by the Arthur Ashe Institute of Urban Health (AAIUH), the New York City (NYC) CBO consortium has a steering committee and lead organizations supporting members to convene as "hubs" organized for each of NYC's five boroughs. CTHE's member organizations provide a range of services to address SDOH across a diverse array of sectors, including economic stability, education, social, family and community, and neighborhood and environmental.[12]

BOX 4. NYC CBOs IN ACTION: LITTLE SISTERS OF THE ASSUMPTION FAMILY HEALTH SERVICE

Little Sisters of the Assumption Family Health Service (LSA Family Health Service) is a neighborhood-based human services organization that has served New York City's East Harlem community for more than 50 years. Staffed and led by community health workers, LSA Family Health Service's Environmental Health Services program has focused on addressing high rates of asthma among the neighborhood's children, mitigating the negative effects of unhealthy living conditions through hands-on remediation, providing caregiver education and skill building, and advocating to promote systemic changes from housing management. The interventions have resulted in statistically significant improvements in health indicators over time, including reduction in the rates of asthma-related emergency department or urgent care visits among families who participate.[13]

Section 2. Delivery System Reform Incentive Payment Programs

Massachusetts and New York are among twelve states with DSRIP and DSRIP-like programs intended to reform their payment and care delivery systems.[14] As such, they provide the perfect context for exploring the role of CBOs in delivery reform. With New York's DSRIP Program beginning in 2014, ahead of the Massachusetts DSRIP program in 2017, the NYC CBO collective was well positioned to provide key lessons for CBOs in Massachusetts.[15]

DSRIP programs are officially authorized under Section 1115 of the Social Security Act, under which the Medicaid program is also authorized. DSRIP programs are approved as "1115 Demonstration Waiver" agreements between the state and federal government. DSRIP programs vary extensively in structure and in scale across states but state programs share a common goal to improve the health of the Medicaid population by addressing SDOH factors or root causes of poor health.[16] See Box 5 for more information about the DSRIP program.

BOX 5. WHAT IS DSRIP?

Delivery System Reform Incentive Payment (DSRIP) programs are officially authorized under Section 1115 of the Social Security Act, under which the Medicaid program is also authorized. DSRIP programs are approved as "1115 Demonstration Waiver" agreements between the state and federal government. They are also known as Section 1115 Waiver programs or DSRIP waivers. States must secure approval from the Centers for Medicare and Medicaid Services (CMS) to proceed with their program and to receive funds to invest in and incentivize delivery reform. DSRIP programs provide states with significant Medicaid funding to support "qualifying" organizations, such as hospitals and other providers, to implement care delivery reforms. Key conditions of DSRIP waivers are: (1) investments made with DSRIP funding must create cost savings that meet or exceed the expenses; and, (2) funds to providers are tied to meeting performance metrics, such as those related to system redesign, clinical health, and population-based improvements. The funds are approved by CMS on a time-limited basis. When the federally-approved DSRIP period ends, the funds end, after which time CMS expects the state's Medicaid program to be able to sustain the achievements of delivery reform. The time-limited nature of DSRIP funds certainly raises the stakes for states, which is why states must be diligent in assessing their DSRIP programs throughout the implementation period and in taking steps to adjust the program as needed. DSRIP offers a vehicle for states to provide Medicaid payments to providers for carrying out infrastructure and care transformation activities that support state and federal health care delivery system reform goals. State programs intend to transform the care delivery system for their Medicaid members in ways that lead to better care, better health, and lower costs.[17]

TABLE 1: DSRIP PROGRAMS IN NEW YORK AND MASSACHUSETTS

	DSRIP In New York	DSRIP in Massachusetts
DSRIP Time Period	New York's DSRIP program is approved by CMS for six years from 2014 to 2020. This time period includes a planning year (2014) and five years of implementation. The program enters the fifth and final year of implementation on April 1, 2019.	The DSRIP program in Massachusetts is approved by CMS for five years from 2017 through 2022. MassHealth, the name for the state's Medicaid program, is in its third year of the DSRIP implementation period including the planning year. The state used 2017 as a planning year and an opportunity to launch the program on a pilot basis in specific regions. The DSRIP program went statewide in 2018.
DSRIP Goals	"To promote community-level collaborations and focus on system reform, [and] specifically to achieve a 25 percent reduction in avoidable hospital use over five years."[18]	To promote a "member-driven integrated and coordinated care delivery system that holds providers accountable for the quality and total cost of care." The state has structured an accountability framework under which the state is accountable to CMS for achieving DSRIP goals.[19]
DSRIP Structure	The program is structured around newly-created entities called Performing Provider Systems (PPSs). PPSs are integrated delivery networks of providers and CBOs that are responsible for implementing a range of projects, which include projects to improve clinical outcomes and population health. 25 PPSs were formed, mostly led by hospitals.[20, 21, 22]	The program is structured around newly-created Accountable Care Organizations (ACOs) and Community Partners (CPs).[23] ACOs are entities that are financially accountable for the cost and quality of member care; they are responsible for providing physical health, BH, LTSS, and health-related social services in an integrated manner. The DSRIP program in Massachusetts is unique in creating the CP program. CPs are responsible for supporting ACO members with significant BH and LTSS needs and addressing SDOH needs of their members. The state's DSRIP program includes 17 ACOs[24], which are largely led by hospitals, as well as 26 CPs, including 18 Behavioral Health (BH) CPs and 8 Long Term Services and Supports (LTSS) CPs.[25] ACOs and CPs work together to support DSRIP goals. CPs provide supports to certain members with significant behavioral health needs and/or complex LTSS needs. When the CP program is fully implemented, MassHealth anticipates that BH CPs will support approximately 35,000 MassHealth members, and LTSS CPs will support approximately 20,000-24,000 MassHealth members.[26]
DSRIP Funds	New York received approval from CMS for $6.42 billion to invest in DSRIP over six years. Under New York's program, the state distributed the funds to PPSs to support the system to achieve DSRIP goals. The state allowed PPSs to design their methodology for distributing funds to their network providers across the DSRIP projects that each PPS had selected; however, PPSs had to make sure to allocate at least 95 percent of the funds to safety-net health care providers to comply with federal requirements.	Massachusetts received approval for $1.8 billion to invest in DSRIP over five years. In Massachusetts, the state has instituted a methodology for distributing funds to ACOs. ACOs are then encouraged to distribute funds to their network providers, including CBOs. The state also designed a methodology for distribution of funds to CPs, whereby the state distributes the funds directly to the CPs, who are, by definition, community organizations. This is a unique attribute to the state's DSRIP program. Over the next five years, the state estimates that it will allocate 60 percent of the $1.8 billion to ACOs and 30 percent to CPs. The remainder of the funds are to be allocated to statewide investments, implementation and oversight.[27]

Under DSRIP, Massachusetts and New York have developed several varying strategies to incentivize health care providers to address SDOH and to promote cross-sector collaboration between HCOs and CBOs around population health goals. See Appendix 1 for examples of the strategies used by both states.

In the early days of DSRIP implementation in New York, the state encouraged its DSRIP lead entities, or Performing Provider Systems (PPSs), to engage CBOs in achieving DSRIP goals and to allocate funding to them. Most of the PPSs were led by hospitals.

Under DSRIP, PPSs were allowed to allocate as much as 5 percent of their funds to non-safety net health care providers such as CBOs.[28] Yet, by the mid-point of DSRIP implementation, CBOs had received only 2.9 percent of all DSRIP funds distributed by PPSs, or less than the 5 percent allowed.[29] CBOs grew frustrated with the reality of the situation. Policymakers and business leaders alike, including CBOs, learned that encouragement from the state was not adequate for promoting cross-sector collaboration. Since these early days, the state has added to its portfolio of strategies, demonstrating to other states that DSRIP programs do not have to be static but can and should evolve and respond to experience. For example, in response to CBO-led advocacy, New York established planning grants for CBOs added value-based contracting requirements to advance CBO engagement in DSRIP.

At the outset, Massachusetts encouraged cross-sector partnerships between CBOs and the health care system. The state demonstrated its commitment in several ways. The state established Community Partners (CPs) to address the need of members with significant behavioral health and long-term services and supports needs and to facilitate their connections to social services to address their social needs. The state created a flexible services protocol with associated funds; required SDOH assessments; and, adjusted Medicaid payments to providers based on the social risks of their clients.[30]

Section 3. Five Key Lessons And Key Reactions

In this section, we describe five key lessons, as developed by the Arthur Ashe Institute of Urban Health (AAIUH) and CTHE. As previously discussed, CTHE, which now includes over 70 diverse CBOs from all five boroughs of NYC, was convened by CBOs in 2014 under the leadership of the AAIUH to strategically plan and collectively develop the infrastructure necessary to ensure robust and sustainable CBO engagement in health system transformation. A key part of that infrastructure is developing the processes necessary to facilitate partnerships with payers (e.g. Managed Care Organizations (MCOs), PPSs) to support CBO-led community engagement, localized community-informed needs analysis[31], and service provision to address SDOH and promote community wellness.

The five key lessons are followed by the reactions from key leaders of a broad cross-section of CBOs in Massachusetts, who participated in small-group listening sessions and semi-structured interviews facilitated by the authors. See Appendix 2 for a summary of the project approach. See Appendix 3 for a list of the MA CBOs that participated in this project; this list also includes CBO mission statements, which reflect their overall desire to promote the health and wellness of the people that they serve and the communities in which they live.

Five Key Lessons from NYC CBOs

The five key lessons from NYC CBOs are presented in Figure 1. Key lesson 1 sits in the center of this figure, because this lesson is foundational to understanding the other four key lessons. That delivery system reform must be rooted in health equity and wellness goals is the most important lesson shared by CTHE and the AAIUH.

Figure 1. Five Key Lessons from NYC CBOs

BOX 6. ARTHUR ASHE INSTITUTE OF URBAN HEALTH (AAIUH) DEFINES AN INTERSECTIONAL LENS

NYC's Arthur Ashe Institute of Urban Health (AAIUH) describes the importance of bringing an intersectional lens to DSRIP service planning and delivery, which CBOs can provide. But what is an intersectional lens, and why is that important? "An intersectional lens is a critical tool that CBOs use to identify and understand the multiple factors that affect the quality of the person's life. This means all factors, be they gender, race, sexual orientation, location of residency, employment status, history of incarceration, and many more. Understanding the whole person serves as a pathway to designing interventions that address the needs of people in a holistic manner, and ultimately, to social justice." Source: AAIUH staff and members of Communities Together for Health Equity (CTHE), including Humberto Brown and Dr. Tenya Blackwell. October 2018.

LESSON 1. DELIVERY SYSTEM REFORM MUST BE ROOTED IN HEALTH EQUITY AND WELLNESS GOALS.

Health equity and wellness must be the primary goals and drivers of delivery reform and DSRIP implementation. CTHE was a driving force in moving New York to identify health equity and wellness as a goal of DSRIP and to value CBOs as essential players needed by HCOs.

To achieve health equity and wellness, Medicaid policymakers, HCOs, CBOs and other stakeholders alike must commit to the long-term task of addressing SDOH at all levels: at the system level, at the community level, and at an individual level. At all of these levels, SDOH factors negatively affect health outcomes. A range of social, economic and environmental factors lead to health inequities, from poverty to racism to inadequate educational opportunities and unsafe work environments.

The health care system alone (or PPSs) cannot improve the poor health of individuals and communities and address the SDOH. Cross-sector collaboration and planning and the specialized use of interventions is required. Successful reform for the system, for community and for individuals requires the participation of diverse CBOs with the required expertise to address the root causes of poor health. The sustainability and success of delivery system reform also depends on making health equity and wellness the core goals. Delivery system reform can tap into the strengths of communities, despite their variaton in strengths, to better understand how each community defines wellness. Understanding how a community defines wellness will support more innovative approaches to addressing SDOH factors.

When NYS designed its DSRIP program, however, the state had not articulated health equity and wellness as established goals. Instead, NYS focused the DSRIP program on health system redesign to improve care and reduce costs, with a significant emphasis on the goal of a 25 percent reduction in avoidable hospital use over five years. These specific DSRIP goals created significant barriers for CBO engagement, which were further compounded by NY's project-oriented framework. Under NY's DSRIP program, PPSs were required to select projects across domains from a set menu.[32] Many of the DSRIP projects selected by PPSs, and the associated performance metrics for the projects, were largely clinical in nature, emphasizing areas that drive hospital and emergency department utilization.[33]

As a result of the DSRIP project emphasis on clinical metrics, many CBOs were not aware of the DSRIP planning process, unless they were already well connected to health care. Putting that connection aside, neither CBOs nor HCOs (with whom CBOs were seeking to partner) had a clear understanding of how CBOs might contribute. CBOs operating food pantries, senior nutrition programs, or immigrant services, for example, were typically not "close enough" to the system changes and to the developing clinical interventions to prevent emergency department use. HCOs did not prioritize CBOs for partnership despite the value they could bring to the planning process, the role they could play in community engagement, and the impact that CBO services to address SDOH could have on health care utilization and costs.[34]

Responding to the barriers faced by CBOs seeking engagement in DSRIP, CBO advocates in NYC joined together to establish CTHE. CTHE advocated that delivery reform must be rooted in health equity and wellness goals to be successful. Rooting delivery reform in health equity and wellness goals would: (1) incentivize meaningful cross-sector collaborations between HCOs and CBOs around health improvements; and, (2) empower and activate CBOs to align with health care efforts and begin to "pull in the same direction." CTHE called on the NYS Department of Health to stand by CBOs and to support CBOs in raising awareness among their CBO peers, and to conduct their own planning process.

NYS responded in a variety of ways. The state began to refer to its DSRIP effort as helping to create a "health equity movement." This position on the part of the state represented a turning point for CBO inclusion; however, CBO participation in DSRIP remained difficult to improve since much of the DSRIP planning processes and project management systems were well established between PPSs and clinical partners. CBOs experienced more frustration, which created another barrier to CBO inclusion.

BOX 7. NYC CBOs IN ACTION: BARBERSHOP TALK WITH BROTHERS (BTWB)

The barbershop program is an example of how CBOs promote health in the community. AAIUH began the barbershop program in 1997 with 10 barbershops in Brooklyn. The progress has grown to over 100 barbershops and uses innovative grassroots strategies to engage men's interest and encourage them to seek health screening and advocate for healthier communities. BTWB is the Institute's community-based initiative to address health promotion in men, utilizing barbershops as the venue.[36]

BOX 8. HEALTH EQUITY DEFINED BY THE ROBERT WOOD JOHNSON (RWJ) FOUNDATION

In a 2017 report published by the Robert Wood Johnson (RWJ) Foundation, the foundation concludes that there is no common understanding of what health equity means, while offering this definition: "health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.[35]

Reactions from CBOs in Massachusetts.
This first lesson, the need to focus on health equity and wellness, resonated strongly with CBOs in Massachusetts. MA CBOs agreed that: (1) health equity and wellness goals should serve as the primary goals of delivery reform in Massachusetts; (2) addressing SDOH needs of members is a critical piece to achieving health equity and wellness; (3) health equity and wellness are complex terms to define and must be responsive to cultural differences across communities; and, finally, (4) achieving health equity and wellness requires cross-sector collaboration to capture the value of CBOs.

CBOs believe that health equity and wellness goals would broaden the framework and lens by which the health care system measures positive outcomes and success. CBO support for health equity and wellness would necessarily affect value-based payment models and contracts.

CBOs offered several examples of measures such as access to suitable housing or access to good jobs that might easily complement or replace health care utilization measures, such as the New York's DSRIP goal to achieve a 25 percent reduction in avoidable hospital use over five years.

CBOs also thought that health equity and wellness goals would serve to empower and activate CBOs to align with health care efforts, as well as to create opportunities for cross-sector collaboration and partnerships between HCOs and CBOs.

CBOs ON HEALTH EQUITY

"There should be a national shift. We need to bring together the community and the medical model."

"Important to think beyond the hospital lens …"

LESSON 2. BRIDGING THE CULTURAL GAP BETWEEN HEALTH CARE ORGANIZATIONS (HCOS) AND COMMUNITY-BASED ORGANIZATIONS (CBOs) REQUIRES A PARADIGM SHIFT.

NYC CBOs found that many HCOs had not taken SDOH factors into consideration. Many HCOs were not aware of the contributions that CBOs could offer to address SDOH factors. On behalf of CTHE, the AAIUH points to this situation as evidence of the cultural gap between CBOs and HCOs, which must be bridged to create meaningful collaboration between HCOs and CBOs.

This cultural gap between CBOs and HCOs is evident on many levels.

On a basic level, CBOs and HCOs often lack a common vocabulary. CBOs speak the language of the community, equity and social justice. HCOs primarily speak the language of health care and medical outcomes. Terms like "quality" and "value-based" hold a different meaning in health care than in community settings. CBOs and HCOs have a different conceptualization of the people with whom they work. CBOs refer to "people" or use the term "clients." HCOs frequently use the term "patients" in reference to the individuals to whom they provide services.

On a deeper level, CBOs and HCOs define responsibility differently. CBOs think in terms of the identified needs of the individual and community; they seek funds to respond to these needs. CBOs define their responsibility to the community at large. HCOs tend to define their responsibilities around their patient panels or attributed lives; they often think in terms of what payers will cover and return-on-investment (ROI) analysis.

CBOs also face a number of funding and operational challenges that deepen the cultural divide between CBOs and HCOs. CBOs typically rely on government contracts, grants, and donations from an array of funders and systems. HCOs receive their funding from more consistent and sustaining payers, such as Medicaid and Medicare. Even more broadly, CBOs have historically been under-resourced and over-burdened. CBOs have a history of facing difficulty in funding overhead and administrative expenses. The CBO administrative infrastructure is often bare bones. The CBO workforce is typically operating at or beyond capacity. CBOs face infrastructure challenges related to information sharing, obstacles to contracting, and delivering expanded services.

While large CBOs may have greater capacity to create a business relationship with HCOs, the AAIUH also points to the important need for large CBOs to form relationships with small CBOs. Relatively small CBOs are uniquely positioned to address populations in need as they are closer to these populations.

In the final analysis, the way in which the health care delivery system functions require a paradigm shift. As HCOs take on responsibility for population health, they must make addressing SDOH the key priority and value CBOs as equal partners in the broader goals for delivery reform.

The AAIUH, on behalf of CTHE, notes that there are several key attributes to successful collaborations between CBOs and HCOs. Key attributes include: (1) the presence of visionary leaders within HCOs who are able to help others within the health care setting to understand/recognize the value of CBO contributions; (2) the use of effective strategies to overcome barriers to HCO and CBO engagement; (3) the adoption of methods and systems to facilitate effective partnerships grounded in mutual respect and trust, which are then reinforced over time; and, (4) a focus on collaborative planning between HCOs and CBOs to address the barriers experienced by the local populations that CBOs serve.

Reactions from CBOs in Massachusetts.

This second lesson, the need for a paradigm shift in the conceptualization of health care delivery, also resonated strongly with CBOs in Massachusetts. MA CBOs recognize that there are many cultural differences between HCOs and CBOs; they agree with NYC CBOs that bridging the culture gap requires a paradigm shift and that this paradigm shift is essential to addressing the needs of individuals and communities.

As one MA CBO said, "We need to right the dynamic."

Many CBOs in Massachusetts support a paradigm shift to bring the medical and community models of care delivery together. CBOs also expressed hope that HCOs and CBOs can build lasting relationships by placing the needs of the person at the center of delivery reform.

CBOs in Massachusetts echoed concerns about their ability to fully engage in delivery reform; they cited their lack of knowledge about DSRIP and their inability to speak the language of the health care system. One CBO in Massachusetts said, "We don't know how to talk the language."

CBOs expressed doubts about the actual possibility of a paradigm shift occurring, because of the power differential between CBOs and HCOs. HCOs have more power, resources, and capacity than CBOs. Moreover, CBOs lack knowledge, resources and capacity to work with HCOs to advance this paradigm shift. As one CBO said, "Our cynicism is in where the commitment is to change – are they even interested in change? I'm not trusting their sincerity."

CBOs in Massachusetts agreed that there is no simple solution to bridging the cultural gap between CBOs and HCOs.

BOX 9. NYC CBO IN ACTION: NORTHWEST BRONX COMMUNITY AND CLERGY COALITION

The Northwest Bronx Community and Clergy Coalition, co-lead of the CTHE Bronx hub, worked with 15 community organizations to address the root causes of poor health to reduce high rates of emergency room visits."[37] NWBCCC is coordinating with other CBOs "to bring community power and vision to transform [the] health system for health equity and long-term sustainability."[38,39]

CBOs ON THE CULTURAL GAP BETWEEN CBOs and HCOs

We brought our project to insurance companies. They didn't take us seriously, just gave us more hoops to jump through. We had to find outside expertise to help us get in the room."

It is important to bring cultural competency into this paradigm shift."

CBOs and ACOs must work together … but, the lack of cultural understanding is a major barrier to providing services to those who need services most."

LESSON 3. SUCCESSFUL REFORM REQUIRES ENGAGEMENT AND EXPERTISE FROM COMMUNITY-BASED ORGANIZATIONS THAT REPRESENT THEIR COMMUNITIES.

CBOs believe that successful reform is tied to having a "seat at the table" and being fully engaged as equal partners in delivery reform. CTHE was established around this very vision.

Throughout DSRIP implementation, CBOs in NYC – and across the state – have experienced frustration and concern around how PPSs defined "CBO engagement" and whether PPSs valued their expertise. CBOs, for example, found that HCOs often limited their participation to that of review (and approval) for plans and models that had already been completed or fully conceptualized by the PPS, leaving little room, or openness, for meaningful participation. The frustration on the part of CBOs was compounded by expectations of ongoing participation with PPSs and contracting arrangements that did not adequately value the contribution of CBOs. CBOs raised even greater concerns about their expertise being sought by PPSs for the purpose of replicating those CBOs services within the PPS without any ongoing relationship with CBOs. CBOs watched as PPSs hired and deployed community health workers/navigator supports or initiated HCO-delivered outreach to specific populations or groups that they were either already serving or better positioned to reach.[40]

BOX 10. WHAT DOES CBO ENGAGEMENT MEAN?

CBO engagement can be defined in many ways. The definitions will naturally vary based on the source of the definition. We offer the two definitions here. The first definition comes from New York's Medicaid program. The second definition comes from Communities Together for Health Equity (CTHE).

New York's Medicaid program defines "partner engagement" as "the PPS having a direct relationship with a partner as evidenced by a contract or other formal agreement. The contract or formal agreement should identify the services to be provided by the partner on behalf of the PPS and the compensation from the PPS to the partner. Partner compensation may be financial or through the provision of a centralized service such as IT or staffing."

CTHE's vision includes building CBO capacity and establishing an infrastructure to facilitate a transformed health care delivery system in which CBOs are active participants in state and local health care planning and community voices provide direct advisement on the use and allocation of state and federal funding. Being a recognized part of New York State planning means that CBOs are included, with respect for their experience and ideas, in all aspects of health planning, such as government and health system policy committees and participation in governing bodies. It means that CBOs have a lead role in the many government-funded "assessments" of their communities and that CBOs regularly present their accomplishments at health conferences and planning and policy forums. CBO participation means that CBOs are recognized as partners by the full range of "payers"— especially those supported by billions in Medicaid funding; and that the state dedicates productive health funding streams to CBOs as it does now for multiple clinical entities, managed care organizations, and other providers.

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CBOs have the expertise that the health care system needs in order to deliver health and wellness interventions that reflect the culture of the people and their communities.[41] CBOs have the trust of communities, and the populations within communities, including those who may not trust formal delivery systems. CBOs are uniquely able to address SDOH needs of Medicaid populations and can even help HCOs to design interventions to implement more traditional, medically-focused initiatives.

From a NYC-based CBO in East Harlem:

"While funding is important, true partnership demands more engagement, which is why it is disappointing that the [state assessment] reports did not offer concrete direction or definition of what engagement means. Up to now, much of the "engagement" that has been described in interviews with CBOs has consisted of little more than one–way communications and directives. Many of the partner organizations have long histories working in their areas of expertise and their neighborhoods; yet they are not being consulted on how to deliver the care that DSRIP aims to increase and expand. The state should encourage (and ideally, monitor) bidirectional engagement that involves collaboration on projects. If the PPSs are not held accountable for effective engagement, DSRIP cannot succeed." (East Harlem Community Health Committee, Inc.)[42]

From a family and children's provider, "It [DSRIP] doesn´t have the ´feel´ of a ´bottom-up´ approach to rebuilding our delivery system, if that is what it was intended to be. (Ken Sass, President–CEO, Family & Children´s Service of Niagara, Niagara Falls, NY)[43]

Across CTHE members, including within AAIUH, are many examples that demonstrate the meaning of this key lesson where CBOs bring their unique expertise to identify local needs and develop customized solutions. These interventions are informed by credible local experts who reach populations that are not effectively served by the health care system. They deliver linguistically and culturally accessible health and community wellness intervention, targeting specific populations or community wellness more broadly.

BOX 11. NYC CBOs IN ACTION: CTHE AND HOME ASTHMA VISITS

In New York City, members of CTHE have pioneered home asthma visits focused on self-care education and home "trigger remediation." These efforts have resulted in many achievements including reduced childhood asthma hospitalizations; and, the first widely available, effective multi-session diabetes self-management education in communities hardest struck by diabetes.

BOX 12. NYC CBOs IN ACTION: SOUTH ASIAN COUNCIL FOR SOCIAL SERVICES, TAKING ON DSRIP GOALS

The South Asian Community (SACSS) in Queens New York received a $700,000 Grant from OneCity Health, a PPS in New York City. This award was made by OneCity Health as part of its Innovation Award Program, created to support the value-based payment environment.[44] Under this grant, SACSS, which is a NYC-based non-profit founded by an Indian-American[45] responsible for implementing the Culturally Responsive Collaborative of Queens project. SACSS leads the project in collaboration with several organizations, Voces Latinas, Polonians Organized to Minister to Our Community (POMOC), The Young Women's Christian Association of Queens, Inc. (YWCA) to "serve the diverse needs of hard-to-reach populations to increase health literacy outcomes and connection to critical healthcare services."[46]

Ensuring that CBOs are fully engaged as equal partners in delivery reform is critical to successful reform; CBOs must have a "seat at the table" to play a meaningful role in delivery reform. For example, CBOs want to form authentic partnerships with HCOs that translate into sustainable relationships, based on trust. CBOs want to develop plans together with HCOs rather than be asked to approve plans that have already been developed by HCOs independently. They want to ensure that PPSs are not duplicating or supplanting the role of CBOs in the system by "building" when they can "buy" community-based services targeting SDOH.

Finally, CBOs believe that HCOs should actively reach out to CBOs, as the partnerships essential for successful reform are not likely to happen on their own.

Reactions from CBOs in Massachusetts.

MA CBOs concurred with the importance of the third lesson, the need for HCO engagement with CBOs.

CBOs agreed that successful and sustainable reform requires CBO engagement and expertise. They saw cross-sector collaboration and planning as critical elements of DSRIP. As one CBO said, "We deserve to be included – to reach the people in need, we have the trust of the community, and can provide information to community members." CBOs serving small or unique populations were especially concerned about being excluded from DSRIP. As one small CBO, which is focused on the needs of the Southeastern Asian population, expressed, "We serve a very specific population. Very small populations can get lost."

Several other CBOs, however, expressed concerns about their ability to fully engage in delivery reform, citing their lack of knowledge about DSRIP. One CBO said, "I know next to nothing about [the] health care system in Massachusetts." "We are small and trying to keep up with systemic change. We don't know … who to talk to in starting a conversation."

Many CBOs felt dependent upon HCOs to recognize their value and invite them to the table. CBOs expressed difficulty in making the business case to HCOs. Moreover, CBO representatives indicated that ACOs have control over the DSRIP funds, as in NYS where DSRIP funds were controlled by PPSs. CBOs also raised concerns about HCOs engaging CBOs in the short run with the end goal of having those services brought in-house to the exclusion of CBOs, again echoing NYS findings.

CBOs ON ENGAGEMENT AND EXPERTISE

We are allowed into people's house[s] and get information about needs that other systems don't hear – we've surveyed these needs and would value connectivity to get the right services connected."

Collaboration with other CBOs (CBOs collaborating with other CBOs) is vital – otherwise, some [CBOs] will no longer exist through acquisition and competition."

"All voices need to be included – need to add the voices of community members themselves."

We serve a very specific population. Very small populations can get lost."

To have a successful partnership, you must share power; you must share ideals; and, you have to have trust."

LESSON 4. COMMUNITY-BASED ORGANIZATIONS MUST BUILD CAPACITY TO LEVEL THE PLAYING FIELD.

Building capacity is critical for CBOs to level the playing field between CBOs and HCOs.[47] More than one survey has found an imbalance between the size and power of large health systems and CBOs. In one set of survey findings specific to NY, CBOs were found to have low operating margins. [48] Sixty percent of CBOs have no more than three months cash in reserve; about 20 percent are insolvent.[49]

CBOs are mission-driven and are generally not-for-profit.[50] While many HCOs are also not-for-profit, many CBOs face a number of real problems including, "running persistent operating deficits," having "few or no financial reserves," and facing "problems such as lack of access to capital for investment in technology and systemic barriers, which limit opportunities for data sharing and integration."[51,52]

Generally speaking, CBOs can find it difficult to adequately invest in infrastructure. By contrast, HCOs have much larger budgets to support the infrastructure and to cover overhead. This lesson extends to the CBO community itself, where the playing field is also uneven. Larger CBOs are more adequately funded than smaller CBOs, for instance.[53] As a result, disparities in capacity can be played out in the CBO environment apart from HCOs.

For CBOs, the lack of resources can translate into the lack of capacity to fully participate in delivery reform efforts. Administrative infrastructure is minimal, and staff are often over-extended, making it hard to free up time to take on new opportunities. Their infrastructure for information technology may be limited, which makes them unable to engage in partnerships that involve significant data collecting, sharing, and reporting. CBOs may require business planning support and legal assistance needed to effectively manage financial negotiations and contracting.

As NYS implemented its DSRIP program it became clear that in order for CBOs to fully participate, the capacity challenges facing many CBOs required an intervention. The decision to fund the development of three CBO consortia across the state was an explicit response from NYS to the resource constraints confronting many CBOs. Two years after DSRIP began, in 2016, NYS first released a Request for Application (RFA) to help CBOs by providing planning grants.[54]

These capacity deficits require meaningful investment, which CTHE has sought to highlight as a critical issue. At a fundamental and more immediate level, however, CBO capacity building to promote readiness for DSRIP engagement involves basic orientation about the purpose of DSRIP and the vital role that CBOs of all types can play in promoting health and wellness. In NYC, this orientation was especially important for those CBOs whose services address SDOH further upstream, as opposed to those whose services are more directly related to medical and health related interventions.

CTHE's capacity building was heavily focused on recruiting CBOs to come together as a united voice on behalf of the communities they serve. It also included an array of trainings and tools, such as a readiness assessment to support CBOs in identifying their strengths and needs related to contracting with HCOs, and a series of trainings to help participants both understand the dynamics of the value-based payment landscape and frame their activities in terms that would resonate with an HCO partner, learning to "package" their services for the HCO "market." Participants were also supported to use tools to help them identify appropriate outcome measures, determine their service costs per person, develop rates that incorporate overhead costs, and identify necessary IT enhancements, etc.

In addition, CTHE was able to compensate CBOs a minimal amount for their participation in the consortium's development and strategic planning process, facilitating CBOs ability to dedicate staff resources to the work. CTHE's support to its members was also facilitated by the collective's development of an electronic platform on which trainings, updates, and meeting materials could be shared.[56]

Reactions from CBOs in Massachusetts.

This fourth lesson, the need for capacity building of CBOs, resonated with CBOs in Massachusetts, but their agreement was nuanced.

CBOs agreed that they must build capacity to engage fully in delivery reform. For this, they stated the need for funding to build the necessary infrastructure and level the playing field between HCOs and CBOs, although some questioned whether that is, in fact, possible.

MA CBOs acknowledged competition between CBOs in their many shapes and sizes, the diversity of the populations they serve, and the broad range of services provided. As a result, they offered a range of reactions and varied in their eagerness to participate in delivery reform.

Some said that it would never be possible to level the playing field, especially given that the playing field is uneven within the CBO community. Larger CBOs, for instance, would have more power and influence – and greater capacity – to participate in reform

BOX 13. NYS RFA DESCRIBES KEY BARRIERS TO CBO ENGAGEMENT UNDER DSRIP

New York State writes, "With major initiatives such as DSRIP, smaller community organizations are often challenged in how to engage and contract with larger, lead organizations, such as the PPS in DSRIP. These organizations tend to be administratively lean, have fewer resources and also compete with other CBOs for similar funding grants. Additionally, it may be challenging to analyze and present their service mission and enterprise in a business framework for contract arrangements. The administrative time and resources required for such engagements often exceed what individual CBOs have available to analyze the business requirements, and to successfully formulate a business strategy and proposition. Further, such demands may burden the CBO and undermine the resources needed for the CBO to continue to deliver its core services."[55]

CBOs ON CAPACITY

As one CBO said, "We need to develop our capacity, and we need more funds to do so."

than smaller CBOs. (NYS recognized that issue within the CBO community by limiting state support to CBOs with budgets under $5 million.)

CBOs felt that mission alignment was as important as capacity building to promote CBO participation. Some MA CBOs said that they did not want to expand their capacity, because they were already operating at full capacity, and argued instead that DSRIP funds should go directly to services to address SDOH.

CBOs agreed that building capacity is critical for CBOs to fully engage in DSRIP; however, the decision to build capacity – and improve or expand capacity – will ultimately vary among CBOs given the varied nature of CBOs themselves.

LESSON 5. COMMUNITY-BASED ORGANIZATIONS MUST COME TOGETHER AS A COLLECTIVE TO PARTICIPATE IN DELIVERY REFORM.

Many CBO networks and coalitions are active within specific sectors, local communities, and related to specific issues or populations. However, there was not a network or formal mechanism for coordinating CBO planning for engagement in health reform. CBOs in NY found that their individual efforts were amounting to only small gains, as reflected in the state's DSRIP Mid-Point Assessment.[57] They felt the need for a united, CBO-led effort to activate a diverse, representative, and cross sector CBO network. They wanted to be able to advocate as a collective and, ultimately, to respond in a coordinated manner to address the intersectional issues that lie at the root of health disparities.

CTHE brings CBOs together to strengthen their collective voices in pursuit of the common goal of reshaping DSRIP into a more culturally responsive re-design initiative that promotes the health and wellness for all of the diverse communities in New York. CTHE members now have a stronger and louder voice and some key "seats at the table" they did not have prior to coming together as a collective. They engage in activities that increase their capacity to understand and communicate their value, and work with HCOs from a position of strength. CTHE provides a learning environment for and by CBOs to develop training programs, to develop services for HCOs, to share resources to manage relationships with HCOs, and to monitor progress. As a collective, CBOs established goals, created best practices, and designed innovations funded through public and private sources to inform the policy discussion.

CTHE's accomplishments demonstrate the power of coming together as a collective around a common vision and shared mission statement.[58] As described by the AAIUH at a 2018 DSRIP Learning Symposium, CTHE's accomplishments include: recruiting and engaging CBOs to participate, establishing the governance structure for the consortium, developing an IT and communication platform for sharing information, networking, and capacity building, delivering trainings, establishing evaluation frameworks for the coordinating and monitoring activities, and conducting outreach and interviews to PPS leaders and CBO liaisons.

As emphasized by AAUIH in an interview for this issue brief, CTHE has made leveling the playing field between CBOs and HCOs a priority. CTHE has pursued several strategies such as providing training to CBOs, establishing rules of engagement, which include creating a set of principles when designing projects, as well as redefining health equity and wellness from the perspective of the community.

Now, CTHE has entered its implementation phase and members continue to meet in their borough "hubs." They convene community members and groups to identify local priorities for coordinated and collaborative responses, and they have established the systems and processes to coordinate as a collective led by an elected steering committee. Despite the present needs of CBOs at the organizational level, such as required IT enhancements, CBOs participating in CTHE understand how to address community-informed priorities in partnership with their CBO peers and the HCOs in their region.

Reactions from CBOs in Massachusetts.

In Massachusetts, CBOs gathered for the listening sessions saw the benefit of coming together as a collective to level the playing field between HCOs and CBOs. As one CBO said, "A collective has more power and access to other tables."

CBOs also saw the benefit of coming together to define their roles in DSRIP. "Health care providers have defined us, and we have to define ourselves."

CBOs expressed a desire to engage in DSRIP but in ways that aligned with their missions and commitment to social justice. Some CBOs, however, acknowledged the challenges associated with coming together as a collective. Time and resources are the big issues. CBOs have "competing interests and we don't have time to make relationships."

From a CBO in Massachusetts

> **"A collective has more power and access to other tables."**

Section 4. Final Thoughts

Both NYC and MA CBOs provide convincing reasons for elevating the role of CBOs in the delivery system and for setting health equity and wellness as the goal of any system reform. This issue brief also highlights current and potential barriers to positive collaboration between CBOs and HCOs.

Striving for health equity is not new. It is consistent with the stated goal of Healthy People 2020, calling for the "attainment of the highest level of health for all people."[59] Achieving health equity requires both will and commitment on the part of states to shift the health care delivery paradigm away from a solely medicalized understanding of health to one that recognizes the sociopolitical context as fundamental to health and wellness.

This issue brief provides information that can help HCOs, CBOs and Medicaid programs operationalize health equity and wellness efforts. Working to achieve health equity and wellness in Medicaid populations requires health care delivery systems to value the contributions of CBOs of all sizes as well as HCOs.

The key lessons shared by NYC CBOs and the reactions to those lessons by MA CBOs point to the vital role of CBOs in advancing health equity and wellness. These key lessons and reactions also emphasize the challenges of developing sustainable partnerships between CBOs and HCOs.

We hope information provided in this issue brief will generate discourse at all levels of the health care delivery system. We also believe that the findings in this issue brief call for a stronger and aligned base of support for the development of a ***National Blueprint for Advancing Health Equity Through Community-Based Organizations*** to facilitate greater cross-sector collaboration between CBOs and HCOs.

APPENDIX 1. SDOH STRATEGIES

TABLE 1: DSRIP PROGRAMS IN NEW YORK AND MASSACHUSETTS

Strategy	Description
New York (NY)	
Encouraging Performing Provider Systems (PPSs) to Engage CBOs and to Allocate DSRIP Funds to CBOs	To encourage PPSs to engage CBOs to address SDOH factors and to allocate funding to them. (Note: It is important to note that we recognize that this is not a strategy per se, as much as an option that PPSs had to engage CBOs and to allocate funds to CBOs. Under the terms of the DSRIP waiver, PPSs were required to allocate 95 percent of their funds to safety-net providers. This meant that PPSs could allocate 5 percent of their funds to non-safety net providers including CBOs. As it turned out, CBOs did not receive 5 percent of the funds from PPSs when measured.
Awarding Planning Grants to Community Based Organizations (CBOs)	To help small CBOs, in 2016, the State announced three grants in the amount of $1.5 million each to CBO lead entities. Grants were made to support the formation of three regional CBO consortia. Each consortium built and/or is building collective infrastructure for CBO and delivery system collaboration, providing training and capacity building to help CBOs to contract with PPSs, and to develop a strategic plan to support continued engagement in the health care system.[60] This strategy was deployed by the state in response to a CBO-led advocacy effort. Small CBOs defined as those that are not billing Medicaid and have annual operating budgets under $5 million.
Establishing the Bureau of SDOH within the Department of Health (DOH)	To bring a new level of focus to SDOH, in 2017, the state established the Bureau of Social Determinants of Health[61] to work on the social determinants of health, including supportive housing, nutrition, and education. It works closely with PPS, value-based purchasing contractors, health plans, and provider organizations."[62] (Note: The state created this new bureau by taking the already-existing Bureau of Supportive Housing and renaming it along with expanding its responsibilities.)
Requiring VBP Contracting Entities to Contract with CBOs and Address SDOH	To facilitate CBO engagement, in January 2018, the state began requiring that every value-based payment contract include at least one CBO contract to address SDOH.[63] According to the state's annual update on VBP: "Though addressing SDH needs at a member and community level will have a significant impact on the success of VBP in New York State, it is also critical that community-based organizations be supported and included in the transformation."[64]
Massachusetts (MA)	
Establishing Community Partners (CPs)	To support certain ACO and MCO members with significant behavioral health and/or long-term services and supports needs, the state established new entities, called Community Partners (CPs). CPs are community-based entities that work with ACOs and MCOs to provide care management and coordination to eligible members.
Creating a Flexible Services Fund	To address SDOH needs of members, the state created a fund for "Flexible Services," which was defined under the 1115 waiver agreement between the state and CMS. Flexible services may address the health-related social needs of ACO members.
Requiring SDOH Assessments	To improve the identification of the social needs of members, the state required: (1) ACOs to assess SDOH needs of their members; and, (2) CPs to assess SDOH needs of CP members. The assessment includes questions about housing, employment and food insecurity needs.
Adjusting Medicaid Payments to Providers for Social Risk	To improve the accuracy of payments made to providers and plans, the state established a methodology for adjusting the total cost of care (TCOC) benchmarks for ACOs, and capitation rates for managed-care plans, based on key SDOH factors including the stability of housing status and neighborhood stress.[65] This methodology helps to improve the accuracy of the TCOC benchmarks for ACOs and the accuracy of the payments to MCOs, which is key to ensuring that ACOs and MCOs are not penalized for addressing members with high social needs.

APPENDIX 2. PROJECT APPROACH

Approach Used to Develop Key Lessons from New York

The five key lessons from New York were developed by The Arthur Ashe Institute for Urban Health (AAIUH), based on its lessons learned as the lead for Communities Together for Health Equity (CTHE). CTHE is a consortium of New York City (NYC) CBOs. The authors supported the development of these key lessons by working in partnership with the AAIUH. We turned to the AAIUH for the development of the key lessons, because the AAIUH is the lead organization for CTHE, and because they have direct experience as a CBO in implementing DSRIP in New York and in developing programs to address SDOH. The AAIUH is one of the three lead CBO entities awarded a planning grant by New York to support strategic planning activities to facilitate CBO engagement in DSRIP projects with PPSs and Value-Based Payment (VBP) activities, including contracting.

Approach Used to Develop Key Reactions for Massachusetts

Key reactions from MA CBOs to the key lessons from NYC CBOs are meant for a broad audience of readers including Massachusetts. Given the differences between New York and Massachusetts, and the differences in the structure and scale of their DSRIP programs, we wanted to bring CBOs in Massachusetts together to collect their reactions to the key lessons offered by New York's CBOs. Most of all, we wanted to find out if the key lessons from New York resonated with CBOs in Massachusetts, and if applicable, their considerations of the barriers and opportunities in applying these lessons to the Massachusetts environment.

To collect the reactions of CBOs in Massachusetts, we organized three 90-minute listening sessions. We held two sessions in Boston and one session in Worcester. We invited 40 CBOs to join the listening sessions. We engaged a total of 19 CBOs in this project. That includes 14 CBOs who joined the listening sessions and five CBOs whom we interviewed by phone.

Prior to the listening sessions, we provided CBOs with a description of our project and its goals. We also provided a summary of the key lessons. At the listening sessions, we asked CBOs why they joined the meeting today, and then we provided an explanation of each key lesson and asked CBOs for their reactions. To generate these reactions, we asked CBOs three prompting questions: (1) Does this key lesson resonate with you? (2) Does this key lesson apply to Massachusetts? (3) What are the key considerations for Massachusetts?

APPENDIX 3. LISTENING SESSION PARTICIPANTS FROM MASSACHUSETTS

TABLE A.2: CBOs IN MASSACHUSETTS

	Community Based Organizations (CBOs)	Mission Statement
	Smallest	
1	Rebuilding Together Boston, Inc.	To assist low-income Boston homeowners (veterans, elderly, the physically challenged, fami need) and non-profits.
2	Southeast Asian Coalition of Central MA	To help Southeast Asians in Central Massachusetts become projective and successful citize identity, and promoting and encouraging civic engagement.
3	THRIVE Communities of Massachusetts	To empower communities by creating spaces that welcome and support our neighbors tran
4	Fresh Truck, Inc.	To radically impact healthcare by celebrating community food culture and getting healthy foo
5	Community Works, Inc.	To provide financial support for charitable/educational organizations.
	Subtotal	
	Mid-Size: Low	
6	The Vietnamese American Initiative for Development, Inc.	To build a strong Vietnamese community and a vibrant Fields Corner through the following n building; developing affordable housing and commercial space; providing small business tec quality child care services.
7	Transition House, Inc.	To address domestic violence intervention and prevention by serving people of all ages and change to end the perpetuation of gender-based violence.
8	Women's Lunch Place, Inc.	To provide meals & critical services to women experiencing homelessness and poverty.
9	Haley House, Inc.	To provide basic needs of food and shelter to poor and homeless individuals.
10	Alliance of Massachusetts YMCAs, Inc.	To represent the 29 YMCA Associations with over 85 facilities and 700 service locations thro operational budgets from several million to tens of millions, but each is responding to pressi healthy living, and social responsibility, which includes an emphasis on equity, diversity, and
	Subtotal	
	Mid-Size: High	
11	Ascentria Care Alliance, Inc.	To provide support to subsidiary charitable organizations.
12	CENTRO, Inc.	To provide strength and unity within the Latino community of Worcester, Mass., through serv recreational, educational, and political problems within the city.
13	Community Servings, Inc.	To provide food and nutrition services throughout Massachusetts to individuals and families
14	Fair Foods, Inc.	To provide surplus goods at low or no cost to those in need. Since 1988 we have rescued a quality building supplies to low income communities throughout New England and around th
15	Inquilinos Boricuas en Accion, Inc. (IBA)	To empower and engage individuals and families to improve their lives through high-quality a
16	St. Francis House, Inc.	To rebuild lives by providing refuge and pathways to stability for adults.
	Subtotal	
	Largest	
17	Rosie's Place, Inc.	To provide a safe and nurturing environment that helps poor and homeless women maintain lives.
18	Catholic Charities of Worcester County	To meet the needs of the poor, the homeless and the infirm and to enhance the quality of life Church and the pastoral leadership of the Bishop of Worcester.
19	Worcester Community Action Council, Inc.	To help people move to economic self-sufficiency through programs, partnerships, and advo
	Subtotal	
	CBOs by Mission	
	All CBOs	
	% of CBOs by Mission	

The authors grouped CBOs based on estimated annual revenue.

	Food	Shelter and Housing	Social and Support Services, Referrals & All Other	Specific Ethnic
lies with children, single parent households and others in		x	x	x
ns while continuing to maintain their unique cultural	x		x	x
sitioning from incarceration.			x	
od to families that need it most.	x			
			x	
	2	1	4	2
measures: promoting civic engagement and community chnical assistance and micro-enterprise; and offering high		x	x	x
backgrounds as we work toward social equity and system	x	x	x	
	x		x	
	x	x	x	
oughout the Commonwealth. Ys range in size of ng community needs, with a focus on youth development, inclusion.	x	x	x	x
	4	4	5	2
	x	x	x	x
vices that address the social, economic, cultural,	x		x	x
living with critical and chronic illnesses.	x		x	
and delivered millions of pounds of fresh produce and he world.	x			
affordable housing, education, and arts programs.		x	x	x
	x	x	x	
	5	3	5	3
their dignity, seek opportunity and find security in their	x	x	x	
e for all, inspired by the teachings of Jesus Christ and the	x	x	x	x
ocacy.			x	
	2	2	3	1
	13	**10**	**17**	**8**
	19	**19**	**19**	**19**
	68%	**53%**	**89%**	**42%**

APPENDIX 4. HELPFUL RESOURCES

1. Blue Cross Blue Shield of Massachusetts Foundation. The MassHealth Waiver 2016-2022: Delivering Reform, January 2017. https://bluecrossmafoundation.org/sites/default/files/download/publication/MassHealth_Waiver_Jan17_report_v06.pdf

2. Blue Cross Blue Shield of Massachusetts Foundation. How are Massachusetts Community-Based Organizations Responding to the Health Care Sector's Entry into Social Determinants of Health? 2018. https://bluecrossmafoundation.org/publication/how-are-massachusetts-community-based-organizations-responding-health-care-sector%E2%80%99s

3. Blue Cross Blue Shield of Massachusetts Foundation. What to Know About ACOs: An Introduction to MassHealth Accountable Care Organizations, July 2018. https://bluecrossmafoundation.org/sites/default/files/download/publication/ACO_Primer_July2018_Final.pdf

4. Executive Office of Health and Human Services. Section 1115 MassHealth Demonstration Waiver. https://www.mass.gov/service-details/1115-masshealth-demonstration-waiver

5. Greater New York Hospital Association | The New York Academy of Medicine. Partnerships Between New York City Health Care Institutions and Community-Based Organizations. A Qualitative Study on Processes, Outcomes, Facilitators, and Barriers to Effective Collaboration, April 2018. https://nyam.org/media/filer_public/9f/5b/9f5b33a3-0795-4a1a-9b90-fa999e9ddf8e/hco_cbo_partnerships_digital.pdf

6. Human Services Council of New York, Integrating Health and Human Services: A Blueprint for Partnership and Action, 2018. https://humanservicescouncil.org/wp-content/uploads/Initiatives/ValueBasedPayment/Value-Based-Care-Report.pdf

7. New York. New York 1115 Medicaid Waiver Information; CMS Official Documents. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/cms_official_docs.htm

8. New York. A Path Toward Value-Based Payment, June 2016: Year 2, See page 42 for CBO requirement. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/2017/docs/2016-06_vbp_roadmap_final.pdf

9. New York. Contracting Strategies: Community Based Organizations Value-Based Payment (VBP) Guidance Document September 2017. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_u/docs/contracting_strategies-cbo.pdf

10. New York. Value Based Payments and Community Based Organizations, July 2018. https://www.health.ny.gov/health_care/medicaid/redesign/sdh/docs/2018-07-11_vbp_cbo.pdf

11. State Health Value Strategies (SHVS). Medicaid and Social Determinants of Health: Adjusting Payments and Measuring Health Outcomes, July 2017. https://www.shvs.org/wp-content/uploads/2017/07/SHVS_SocialDeterminants_HMA_July2017.pdf

12. HMA Experts Contribute to Report on Health Disparities in Minnesota's Medicaid Population. Health Management Associates. https://www.healthmanagement.com/blog/hma-experts-contribute-report-health-disparities-minnesotas-medicaid-population/ https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7834-ENG

Endnotes

1. In this issue brief, the authors use: (1) the term Community Based Organization (CBO) to represent a range of organizations that vary in mission, size and focus; and, (2) the term health care organization (HCO) to represent a range of health care providers from hospitals to primary care practices to Accountable Care Organizations (ACOs) to Performing Provider Systems (PPSs) operating under New York's Delivery Reform Incentive Payment (DSRIP) program.
2. DSRIP programs are officially authorized under Section 1115 of the Social Security Act, under which the Medicaid program is also authorized.
3. The authors worked with The Arthur Ashe Institute of Urban Health (AAIUH), the lead agent for Communities Together for Health Equity (CTHE), to develop the key lessons from New York. CTHE is a self-governed coalition of community-based organizations (CBOs) that serve Medicaid and Medicaid Managed Care beneficiaries and uninsured residents in NYC. CTHE's member organizations represent the communities where Medicaid populations are concentrated, reflect the diversity of the human service sectors addressing the social determinants of health (SDOH), and mirror the populations of greatest need for targeted attention. CTHE's founders came together to advocate for meaningful and intentional activation of the community-based care delivery system within the State's $6.42 billion Delivery System Reform Incentive Payment (DSRIP) program.
   - The Arthur Ashe Institute of Urban Health (AAIUH). https://www.arthurasheinstitute.org/
   - The Communities Together for Health Equity. https://cthe.us/
4. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States. Communities in Action, Pathways to Health Equity. January 2017. https://www.ncbi.nlm.nih.gov/books/NBK425848/
5. Research and articles related to the role of SDOH in health outcomes:
   - Braveman, Paula MD, MPH and Gottlieb, Laura MD, MPH. The Social Determinants of Health: It's Time to Consider the Causes of the Causes. 2014 Jan-Feb; 129(Suppl 2): 19–31. [PMC free article] [PubMed] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863696/
   - Center for Health Care Strategies. Advancing Partnerships between Health Care and Community-Based Organizations to Address Social Determinants of Health: Executive Summary. August 2018. https://www.chcs.org/media/KP-CBO-Exec-Summ__080918.pdf
6. CBOs from New York City and CBOs in Massachusetts emphasized that they are directly connected with the populations that they serve, which provides for opportunities for cross sector relationships with HCOs.
7. Center for Health Care Strategies, Inc. (CHCS). An Inside Look at Partnerships between Community-Based Organizations and Health Care Providers, October 2017. https://www.chcs.org/inside-look-partnerships-community-based-organizations-health-care-providers/
8. Center for Health Care Strategies, Inc. (CHCS). Partnering to Improve Population Health: Exploring Effective Community-Based Organization and Health Care Models, July 2017, https://www.chcs.org/partnering-improve-population-health-exploring-effective-community-based-organization-health-care-models/
9. Research and articles related to the importance of cultural competency:
   - Center for Migration Studies, Nicholson, M. The Role of Faith-Based Organizations in Immigrants' Health and Entrepreneurship. http://cmsny.org/publications/2018smsc-nicholson/
   - National Research Center on Hispanic Children and Families, Developing Culturally Responsive Approaches to Serving Diverse Populations: A Resource Guide for Community-Based Organizations. Michael López, Kerry Hofer, Erin Bumgarner, and Djaniele Taylor. March 2017. https://www.nsvrc.org/sites/default/files/2017-06/cultural-competence-guide.pdf
10. Center for Health Care Strategies, Inc. (CHCS). Partnering to Improve Population Health: Exploring Effective Community-Based Organization and Health Care Models. July 2017. https://www.chcs.org/partnering-improve-population-health-exploring-effective-community-based-organization-health-care-models/
11. Note that CTHE in general, as a collective, is inclusive of CBOs of all sizes; however, the over 70 members and the consortium's activities described and funded by the planning grant are limited to small CBOs.
12. Communities Together for Health Equity (CTHE). https://cthe.us/
13. Research and articles related to case study about Little Sisters of the Assumption Family Health Service:
   - The New York Academy of Medicine. A Community Health Worker Model to Address Childhood Asthma: Perspectives of Program Participants. 2017. https://littlesistersfamily.org/wp-content/uploads/2017/09/2017-9_NYAM-CHW-Report.pdf
   - Greater New York Hospital Association. (2018). Partnerships Between New York City Health Care Institutions and Community-Based Organizations. 2018. https://www.gnyha.org/wp-content/uploads/2018/04/HCO_CBO_partnerships_digital.pdf
14. According to the National Academy for State Health Policy, there are 12 states that have DSRIP and DSRIP-like programs. See also: MACPAC. Issue Brief Delivery System Reform Incentive Payment Programs. March 2018. https://www.macpac.gov/wp-content/uploads/2018/03/Delivery-System-Reform-Incentive-Payment-Programs.pdf
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16. MACPAC. Issue Brief Delivery System Reform Incentive Payment Programs. March 2018. https://www.macpac.gov/wp-content/uploads/2018/03/Delivery-System-Reform-Incentive-Payment-Programs.pdf
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18. New York State Department of Health. DSRIP Overview. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/overview.htm
19. Attachment M. The State's Delivery System Reform Incentive Payment (DSRIP) Protocol Document. https://www.mass.gov/files/documents/2017/05/zm/dsrip-protocol.pdf
20. New York State Department of Health. New York State Delivery System Reform Incentive Payment Program Project Toolkit. Authors' note: New York's menu of projects included projects focused on system transformation, clinical improvement and population health improvement. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/dsrip_project_toolkit.htm
21. PPSs were required to designate major public hospitals and other safety-net providers as the lead entities eligible to receive DSRIP funds. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/dsrip_faq/section2_faqs.htm
22. Medicaid.gov. Medicaid 1115 Demonstrations. Examining New York's Delivery System Reform Incentive Payment Demonstration: Achievements at the Demonstration's Midpoint and Lessons for Other States *Laurie Felland, Debra Lipson, and Jessica Heeringa*. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/ny-dsrip-case-study.pdf
23. The Community Partners (CP) program also includes existing Community Service Agencies (CSAs). This can be found in Attachment M. Massachusetts Delivery System Reform Incentive Payment (DSRIP) Protocol. https://www.mass.gov/files/documents/2017/05/zm/dsrip-protocol.pdf
24. Mass.gov. Press Release. MassHealth Partners with 17 Health Care Organizations to Improve Health Care Outcomes for Members. August 2017. https://www.mass.gov/news/masshealth-partners-with-17-health-care-organizations-to-improve-health-care-outcomes-for
25. Mass.gov. MassHealth Selects 26 Community Partners to Help Improve Health Care for 60,000 Members. August 2017. https://www.mass.gov/news/masshealth-selects-26-community-partners-to-help-improve-health-care-for-60000-members
26. MassHealth. Payment and Care Delivery Innovation. Fact Sheet on Community Partners. October 2018. https://www.mass.gov/files/documents/2018/10/17/PCDI-FS-CP-10-17-18.pdf
27. MassHealth DSRIP Investments. Executive Office of Health and Human Services Presentation. Updated March 2018. https://www.mass.gov/files/documents/2018/03/15/DSRIP%20Statewide%20Investments%20Overview%20March%202018_v2.pdf
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29. New York State Department of Health. Mid-Point Assessment Action Plan Final Summary. Mid–Point Assessment Action Plan Final Update, March 2018. The PPS funds flow distributions as of DY2, Q2 showed that 2.9 percent of total DSRIP funds were distributed to CBOs. As of DY3, Q2, PPS funds flow distribution increased to 3.02 percent. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/mid-pt_assessment/2018-03_mid-pt_action_final.htm
30. The authors' note that as Massachusetts implement its DSRIP program, we expect to see an increased focus on the role of CBOs in care delivery reform.
31. CBOs believe that they can provide much more targeted local insight about access barriers and wellness gaps than the needs assessments conducted by hospital-based PPSs are often limited by the available local data.
32. New York State Delivery System Reform Incentive Payment Program Project Toolkit. https://www.health.ny.gov/health_care/medicaid/redesign/docs/dsrip_project_toolkit.pdf
33. Examining New York's Delivery System Reform Incentive Payment Demonstration: Achievements at the Demonstration's Midpoint and Lessons for Other States. April 2018. https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/ny-dsrip-case-study.pdf
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37. Northwest Bronx Community and Clergy Coalition, 2017 Annual Report. https://static1.squarespace.com/static/5a2021c5e5dd5b3a4dda00d4/t/5abff032aa4a998a3b6f0572/1522528311119/2017+Annual+Report+Website_Reduced.pdf
38. Northwest Bronx Community and Clergy Coalition, 2017 Annual Report. https://static1.squarespace.com/static/5a2021c5e5dd5b3a4dda00d4/t/5abff032aa4a998a3b6f0572/1522528311119/2017+Annual+Report+Website_Reduced.pdf
39. https://www.health.ny.gov/health_care/medicaid/redesign/sdh/summit_docs/finalist_cp_nwbronxcomm.pdf
40. DSRIP Mid-Point Assessment, Public Comment Documents. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/pps_map/midpoint/2016-12-22_midpoint_pblc_com.htm
41. Readers should note that this issue brief only addresses the expertise of CBOs, while we recognize that HCOs
42. Authors' note: This is testimony provided at a public hearing.
43. Authors' note: This is testimony provided at a public hearing.
44. OneCity Health Innovation Award Program. "On June 12, 2018, OneCity Health announced the eight community partners that will receive funding from its $5 million Innovation Fund to implement programs targeting DSRIP priorities and the public health system transformation goals, including reducing avoidable hospitalizations, improving community health outcomes, and addressing social determinants of health, such as food security and health literacy." https://www.onecityhealth.org/innovation-award-program/
45. South Asian Council for Social Services (SACSS). https://www.sacssny.org/about-us.html
46. Press Release. June 2018. South Asia Council for Social Services. https://www.sacssny.org/assets/SACSS%20CRCQ%20Press%20Release.pdf
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Community-Based Organizations and Health Care Providers. October 2017. https://www.chcs.org/inside-look-partnerships-community-based-organizations-health-care-providers/
48. DSRIP Learning Symposium. Facilitating Effective, Sustainable Health Care – CBO Partnerships. February 2018. http://www.dsriplearning.com/2018/library/presentations/breakout-sessions/D5_CBO%20Partnerships.pdf
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50. New York State Department of State, Division of Corporations, State Records and Uniform Commercial Code, New York. "Not-for-profit corporations may not be formed for profit or financial gain. Additionally, no corporate assets, income or profit may be distributed to the corporation's members, directors or officers unless permitted by the NPCL." The NPCL stands for the Not-for-Profit Corporation Law. https://www.dos.ny.gov/forms/corporations/1511-f-l_instructions.pdf
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53. Oliver Wyman and SeaChange Capital Partners. A National Imperative: Joining Forces to Strengthen Human Services in America is a report commissioned by the Alliance for Strong Families and Communities and the American Public Human Services Association (APHSA). 2017. Authors' note: the summary findings presented in this issue brief are based on the findings included in the report: A National Imperative: Joining Forces to Strengthen Human Services in America. http://www.alliance1.org/web/community/national-imperative-joining-forces-strengthen-human-services-america.aspx
54. CBO advocacy informed NYS to release a Request for Application (RFA) to support CBO engagement in healthcare transformation through a planning grant. Research and articles related to Community Based Organization Planning Grant.
    - The state issued this Request for Applications (RFA) in 2016: Request for Applications (RFA) #1512160408, Grants Gateway ID: DOH01-CBOPG-2016 New York State Department of Health; Office of Health Insurance Programs, DSRIP Program Request for Applications, Community Based Organization (CBO) Planning Grant. https://www.health.ny.gov/funding/rfa/inactive/1512160408/
    - The state issued this RFA second: Community Based Organization (CBO) Planning Grant Reissue for the Rest of State Region. Request for Applications #17799, Grants Gateway ID: DOH01-CBORS3-2018 New York State Department of Health. https://www.health.ny.gov/funding/rfa/17799/index.htm
55. Refer to: RFA # 1512160408 / Grants Gateway # DOH01-CBOPG-2016; New York State Department of Health Office of Health Insurance Programs, DSRIP Program, Request for Applications: Community Based Organization (CBO) Planning Grant. https://www.health.ny.gov/funding/rfa/inactive/1512160408/
56. Communities Together for Health Equity (CTHE). https://cthe.us/
57. New York State Department of Health. DSRIP Mid-Point Assessment. https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/mid-pt_assessment/index.htm
58. Communities Together for Health Equity (CTHE) and shared at the 3rd Annual New York State DSRIP Learning Symposium held Feb 6-8, 2018. Marilyn Fraser, CEO of the Arthur Ashe Institute for Urban Health, presented on behalf of CTHE on a CBO Consortium Panel Discussion on Wednesday, February 7, 2018. Community Based Organization Consortium Panel. http://www.dsriplearning.com/2018/library/presentations/breakout-sessions/B4_CTHE_Presentation_PPS_LearningSymposium-Final.pdf
59. Healthy People 2020. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities
60. The state selected two grantees to represent two regions of the state including the AAIUH for NYC and Health and Welfare Council for Long Island (HWCLI) for Long Island and Hudson Valley. The third grant, covering the rest of state, has not yet been awarded.
    - http://www.ahihealth.org/wp-content/uploads/2016/03/DSRIP-News-6.3.16.pdf
    - http://www.hwcli.com/tag/dsrip/
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62. Open Minds. New York Establishes Bureau of Social Determinants of Health, December 2017. https://www.openminds.com/market-intelligence/bulletins/new-york-establishes-bureau-social-determinants-health/
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65. Mass.gov. MassHealth Risk Adjustment Methodology. https://www.mass.gov/lists/masshealth-risk-adjustment-methodology