LIFT OFF:

Partnerships to Address Health-Related Social Needs

A Report on the MassHealth Accountable Care Organizations & Community-Based Organizations Collaboration

Year 3

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Background

Health-related social needs (HRSNs), such as housing and food insecurity, arise from social and economic factors and have a significant impact on individuals' health outcomes and costs. HRSNs are also sometimes referred to as social determinants of health (SDOH), but HRSNs are specific to individuals, while SDOH are systemic in nature. In 2017, MassHealth – the Massachusetts Medicaid program – launched a multi-faceted Accountable Care Organization (ACO) program, which included requirements for HRSN screening and targeted funding to address HRSNs for certain MassHealth members. The HRSN effort is administered through the Flexible Services Program ("FSP," or "FS program,"). Launched in 2019 and operationalized in 2020, the FSP leverages partnerships between ACOs and community-based organizations (CBOs) to address HRSNs related to housing and nutrition. This report identifies key findings, challenges, best practices and policy recommendations based on the third year of structured interviews with ACOs and CBOs about their partnerships to address HRSNs under the FSP.

Study Design & Setting

This qualitative study was conducted by Health Care For All (HCFA) in collaboration with the Alliance for Community Health Integration (ACHI) and the Massachusetts Public Health Association (MPHA). The study was also supported by graduate students from the Harvard T.H. Chan School of Public Health (HSPH) and Boston University School of Public Health (BUSPH). The study was made possible thanks to the generous support of The Boston Foundation.

The research team conducted interviews with employees from nine MassHealth ACOs and ten Massachusetts CBOs. The CBOs were selected to represent a range of organizational size and to ensure representation from the two domains targeted under the ACO program – housing and nutrition. The individuals from the ACOs had knowledge and involvement in their respective ACO's HRSN programing. The CBO interviewees held organizational leadership positions and interfaced with the ACOs on HRSN collaborations under the FSP.

In addition to the interviews, answers to pre-interview questions from both ACOs and CBOs

Methods

Design | Qualitative study with semi-structured interviews with organizational staff from ACOs and CBOs serving Massachusetts area, ranging in size, domains, and design. Conducted 3/2021 - 5/2021.

Participants | Leadership from 9 MassHealth ACOs + 10 CBOs

Analysis | NVivo-assisted transcription; coding using thematic analysis principles.

Questions were grouped into six categories:

1) Implementation of Flexible Services
2) Evaluation of Flexible Services
3) Successes & Challenges
4) Collaboration with ACO/CBO partners
5) Collaboration with MassHealth
6) Future Vision for Flexible Services

provided self-reported quantitative information. This data supplemented the qualitative findings from interviews on the progress made in implementing the FSP.

Data Collection & Analysis

Interviews occurred in the spring of 2021 using an open-ended interview guide. Each interview was conducted in English and lasted from 30 to 90 minutes and was recorded and transcribed using NVivo, a web-based transcription software. Study team members subsequently reviewed and corrected the transcriptions.

Over the course of year 2 and 3 of the study, transcript analysis was performed by graduate students from HSPH and BUSPH, with support from HCFA staff. Analysis was performed using NVivo R1. Team members developed a catalogue of key concepts referred to as a codebook. The codebook was modeled on the interview questions, with additional categories added for data and overarching themes not easily captured by the interview questions.

The results indicated consistent themes within and across several topic areas that are detailed in the findings sections of this report. Challenges, best practices, and policy recommendations indicated by the findings were also considered.

This research and analysis reflects findings from the specific time when interviews were conducted in the spring of 2021. The landscape will continue to shift as the FSP implementation continues, ACO-CBO collaboration develops further and as additional changes are made through the upcoming 1115 waiver extension negotiations.

COVID-19 Disclaimer

On March 10, 2020, Governor Charlie Baker declared a state of emergency in response to the COVID-19 outbreak, coinciding with many FS programs' planned start dates. All ACO-CBO partnerships had to adapt their strategies to respond to the many logistical challenges presented by the pandemic environment. The timing of the COVID-19 lockdowns caused delays in the launch of many FSP initiatives, which impacted overall referral numbers for the programs. Internal capacity and resources varied across ACOs and CBOs and resulted in some organizations scaling up FSP efforts to respond to rapidly growing community needs during the pandemic, while causing others to delay FSP programing. Many ACO staff members who played a critical role in the FSP were furloughed or redeployed to serve the needs of patients in a non-FSP capacity. CBOs shifted to remote work, which posed significant challenges to engagement with the populations they serve and exposed stark "digital divides" among their clients. The COVID-19 pandemic has undoubtedly had lasting impacts on the health care and social services sectors, some of which can begin to be understood through the reflections and analysis in this report. The findings of this study should be interpreted through the lens of these unique circumstances.

ACO Key Findings

There was wide variation and little consistency in systems used by ACOs to refer FSP participants to CBOs. In many cases, ACOs defaulted to use of secure email. Informal referral methods and tracking included Google Drive and protected Excel spreadsheets. A few ACOs used more sophisticated systems such as Aunt Bertha, an online platform that aims to assist those searching and applying for social services.

ACOs varied in their number of centrally run versus individual clinic-run program sites. ACOs with a greater share of their FS programs run through central locations tended to have a wider geographic reach (sometimes statewide) and had a greater number of ACO members referred to FS programs overall, compared to ACOs with programs operating out of individual clinic sites. However, several regionally based ACOs successfully referred a larger share of their members to FS programming compared to those with a wider geographic distribution.

Many ACOs had relationships with CBO partners prior to the FSP. ACOs prioritized existing relationships with CBOs that had demonstrated success in and knowledge of the communities they serve, prior experiences working with health care providers, and a readiness to take on a larger caseload. Several ACOs developed relationships with CBO partners through other MassHealth-run programs such as the Community Partners (CP) program.

ACOs had positive experiences working with the MassHealth FSP support team. ACOs felt that MassHealth account managers were responsive and acted as conduits for sharing information and program suggestions with the agency. Account managers leveraged their personal expertise across a range of different domains to engage with ACOs and find creative solutions to problems.

All ACOs interviewed were moving forward with FS programing, and voiced enthusiasm for the program's efforts. This is notable given the challenge FSP partnerships presented, the skepticism expressed by some in previous year interviews, and the challenge of launching the program during 2020, when the pandemic was at its peak in Massachusetts. This finding was also reflected in pre-interview quantitative responses that indicated significant, if still somewhat limited program participation.

ACO Challenges

Limitation of individual based programing: All ACOs expressed the need to shift from an individual to a family-level approach. ACOs noted that in many cases, services and supports were being utilized by a whole household rather than by the patient alone, which can skew reporting and reduce the impact of FSP funds. For example, a home-delivered meal provided to a parent will likely be shared with children in the household if the entire family is food insecure. In that instance, the parent is not getting the full impact of the nutrition support, which is often medically tailored – diluting the impact of the intervention, while still leaving the children with insufficient nutrition support.

Difficulty quickly demonstrating a return on investment: Many ACOs noted having a limited amount of data on outcomes, which was less than necessary to show a return on investment for FS programs given their relatively short duration. ACOs believed that most of the HRSN related interventions could take years, not months, to demonstrate meaningful impact on social, health, and cost outcomes.

Inability to provide the anticipated number of referrals for FS programs: ACOs cited program launch delays due to COVID-19, long turn-around times in serving complex patient needs such as housing insecurity, and low program take-up as barriers to FSP enrollment. This created uncertainty regarding ACOs' ability to spend FSP funds in the allotted time frame. Notably, CBOs had differing perspectives and the wide variation in the number of referrals made across ACOs suggests that other factors, including the extent to which ACOs were committed to FS programs, may play a role in the ability to provide the anticipated number of referrals.

Inflexibility of FSP funds: ACOs shared a desire for FSP funds to be "more flexible," especially in the housing domain. One particular area of consensus was around using FSP funds to pay rental arrears. Some ACOs felt that these funds should also be authorized to pay for emergency accommodations, such as hotels for individuals transitioning into stable housing.

Restrictions on eligibility: ACOs perceived eligibility criteria for the FSP as a limitation on the program's ability to serve patients who have demonstrated HRSNs, but who do not have a physical or behavioral comorbidity. ACOs believed that opening eligibility could significantly increase enrollment numbers as members currently may screen positive for HRSNs but ultimately do not qualify for FSP. However, it was not always clear that the eligibility limitations ACOs referred to were MassHealth requirements. In some cases, the restrictions reflected ACO-level decisions to prioritize certain populations for program eligibility.

Verification, Planning, and Referral (VPR) forms were viewed by ACOs as creating redundancy, posing implementation challenges: ACOs experienced challenges in operationalizing the MassHealth VPR form that is required for referring members from ACOs to CBOs for FS programing. Many felt that it contained "a lot of repeated information," and others expressed that it significantly impeded workflows. However, CBOs raised few concerns, sometimes even expressing gratitude for the information provided in the form, and in certain cases, requesting additional information be provided by the referring ACO.

ACO Best Practices

- **Selection of evaluation metrics beyond MassHealth requirements to detect outcomes:** Many ACOs tracked a number of metrics in addition to those required for FSP evaluation (total cost of care and emergency department utilization). Examples of additional metrics include mental health and stress, resilience and changes in housing and food insecurity status.

- **Aligned organizational culture and executive leadership:** Organizational culture and the engagement of executive leadership highly influenced the reach of MassHealth ACOs' FS

programs. ACOs that have long incorporated HRSNs in their mission and strategy had the most developed FSP network and the best coordination with CBOs.

- **Frequent and transparent communication with CBO partners:** Early and frequent communication between ACOs and CBOs helped build trust and set expectations within partnerships. For example, several ACOs communicated with CBO partners around how to pace referrals, which helped to avoid bottlenecking that could lead to member frustrations.

- **Integration of CBO staff into ACO workflows:** Several ACOs found success by integrating CBO staff members into their usual operations. This ranged from including CBO administrators in weekly huddles and case reviews for complex patients, to providing CBO staff with badge access to their health care facilities.

- **Intentional ACO staff training on client engagement:** Some CBOs co-developed training materials and work plans with ACO partners and facilitated trainings with ACO staff on referral processes including how to describe FS programs to patients and set expectations for next steps. ACOs were then able to reduce the rate of patients lost to follow-up due to refusal, ineligibility, or non-response and to instead increase the rate of successful referrals.

- **Early, continuous shared access to care management systems:** CBOs were highly receptive to when they were given access to ACO care management platforms and records. However, some CBOs noted that their access immediately expired for a client case that was no longer active, creating challenges for evaluation and record-keeping purposes.

- **Use of FSP funds for staffing:** Several ACOs utilized a portion of their FSP funds to add staff positions directly related to the program's operations. These organizations reflected that having a dedicated staff position for FSP made a significant difference in their workflows and freed up staff capacity to take on other tasks. However, it was not clear why these same staff positions could not be supported through other ACO funding streams, suggesting ACOs' potential lack of willingness to support HRSN related programing without a dedicated funding stream.

CBO Key Findings

CBOs noted the importance of educating ACO partners on referral processes and program criteria, including educating referral-making ACO staff on how to correctly describe the interventions to avoid losses to follow-up or inappropriate or ineligible referrals. In several cases, CBOs were able to resolve initial challenges regarding member misunderstanding and refusal of FS programming through rapid course corrections and trainings for ACO staff.

CBOs had little bi-directional communication and formal engagement with MassHealth. While Most CBOs were content with minimal communications from MassHealth, there was a

common need for basic communications on their FSP performance, similar to what is currently shared with ACOs.

CBOs found that close client relationships contributed to their ability to provide support. CBOs noted that they were able establish trust to garner pertinent insights into client circumstances which aided their ability to provide supports. One CBO provided an example in which they discovered a change in a client's neurocognitive status (dementia) during a home visit, which, despite the lack of a formal referral process, ultimately led to the client getting additional medical and social supports.

CBOs expressed interest in bi-directional referrals with ACO partners. Several CBOs reflected that while ACOs can refer to CBOs for HRSNs, there was rarely a pathway available to CBOs to refer clients to ACOs for health needs. CBOs noted that clients "may not go to health care first" and that community organizations could be well positioned to facilitate this pathway to medical care.

CBOs encountered uneven power dynamics with ACO partners. Some CBOs acknowledged that this may be due to the inequitable contractual structure in which ACOs control the flow of funds. One CBO highlighted differences in racial, educational, and language backgrounds between their organization and their ACO partner, which at times played a role in this power dynamic and with feedback provided by their ACO.

A majority of partnerships did not have co-located staff or shared workspaces, though a small minority of ACOs did provide CBO staff with badge access to engage with members within their facilities. One housing CBO noted that the shelter where their pre-tenancy support personnel operated had to undergo restructuring in order to better coordinate FSP-related activities.

CBOs reported overall alignment with their ACO partners and with the FSP. Many CBOs felt that their ACO partnerships mirrored their organizational goals, particularly with regards to supporting clients' full range of needs.

> *"We both know that together we can have such a larger impact on health, and that aspect is extremely important."*

CBOs experienced wide variation in expectations and demands from ACO partners. CBOs noted varying intensity in expectations or demands by ACOs. Some indicated their ACO partners were significantly more prescriptive in their evaluation expectations than others, while one CBO recalled that their ACO partner wanted to keep metrics simple in order to better show outcomes.

CBO Challenges

Asymmetries in technological capacity and lack of standardized referral systems: CBOs cited technological asymmetries between their organizations and their ACO partners—who had more expansive capabilities—as one common challenge. Many CBOs utilized Social Service Organization (SSO) Preparation funds provided by the state to scale up their internal systems. However, there was a wide variation in referral systems among ACO partners, which created challenges for CBO workflows, especially for those working with more than one ACO.

Receiving poor quality or inaccurate referrals: A majority of CBOs recalled needing to instruct their ACO partners about referral selection and processes. CBOs found that this likely stemmed from a limited understanding among ACO staff about the services their CBO was able to provide or ACO staff failing to ask pertinent follow-up questions with patients to verify FSP eligibility.

Lower than expected referrals from ACO partners: CBOs reported not receiving the number of referrals that they had anticipated from their ACO partners. Some CBOs did not receive enough revenue from referrals to retain full-time staff. In one example, a nutrition coach could no longer be supported. While some of this deficit could be attributed to delays and roadblocks due to COVID-19, CBOs also cited strict program eligibility originating either from ACOs or MassHealth as an additional cause.

Challenges unique to the housing domain: The lack of safe and affordable housing continues to be a challenge to CBOs adequately assisting their clients. CBOs reflected that though FSP funds can be used to pay first and last month's rent and the security deposit on a new unit, affordable units were often unavailable. Several CBOs further noted a discrepancy between the federal definition of homelessness and clients' self-identification as homeless or expressed need for help due to living in doubled-up housing or a hotel. The discrepancy created challenges for explaining FSP eligibility to members. At times, families, and in some cases ACO staff, thought they would be eligible for shelter through the Emergency Assistance program because they identified as homeless while living in doubled up housing, but were later deemed ineligible. In these cases families did not meet the qualifications for FSP supports which created frustration and potential disengagement among MassHealth members.

Inability to use FSP funds for rental arrears: CBOs described that the inability to use FSP funds to pay back-rent or arrears created housing access hurdles for many individuals despite the ability to pay for first month's rent and security. CBOs explained that for Section 8 voucher holders, the failure to pay overdue rent could result in a loss of their housing voucher and in some cases render them ineligible for shelter for up to 3 years.

Legal and contractual hurdles: Some smaller CBOs lacked the in-house legal capacity to negotiate contracts, favoring Business Associate Agreements (BAAs) and data agreements instead of traditional Memoranda of Understanding (MOUs). Most CBOs desired some level of standardization in ACO contracts. Several CBOs also noted the financial risk inherent to payment structures focused on service completion rather than referrals – and CBOs' organizational capacity to carry risk was limited by their size and financial structures.

Furthermore, many factors beyond CBOs' immediate control impacted successful program completion..

Confusion around how to engage ACOs to launch partnerships: This may have limited some CBOs' ability to engage in fruitful partnerships. One CBO recalled being unsure of the rules of engagement in launching a potential ACO partnership. Specifically, there was lack of clarity as to whether the CBO should approach the ACO with a proposal, or if the ACO would be the one to offer them a contract.

CBO Best Practices

- **External partnerships for evaluation of FSP:** Several CBOs tapped into outside funding resources or partnerships with academic institutions to assess the impact and outcomes of their FSP-specific programs, as well as their unique organizational approaches to services. Many CBOs expressed a desire for studies to be conducted on the impact of FS programs, and some proactively sought out these opportunities for collaboration.

- **Clear communication and expectations between CBOs and ACOs:** Partnerships worked best when CBO staff had open and transparent communication with ACO partners. CBOs stressed the importance of setting expectations early in their partnerships regarding data collection and the frequency of communication.

- **Measuring the impact of anxiety and stress on health:** In addition to metrics provided from their ACO partners, several CBOs were interested in examining the impact of interventions on anxiety and stress caused by food and housing insecurity, and how these stresses relate to clients' health outcomes.

- **Implementation of interoperable referral systems:** CBO-based Application Programming Interfaces (APIs) made referrals between API-compatible CBOs possible, improved time-to-service, and maintained permanent client record access for evaluation purposes. It also helped to consolidate workflows with ACO partners who had compatible APIs.

- **Addressing the digital divide among clients:** In the transition to virtual engagement due to COVID, one CBO identified significant disparities in clients' technological capacity. In response, the organization brought on an in-house technology instructor to provide classes to community members.

Pre-Interview Implementation Progress Survey

In addition to conducting interviews, HCFA disseminated pre-interview surveys to ACOs and CBOs participating in the study. The surveys requested self-reported, quantitative information regarding the number of FS programs (disaggregated by food and housing domains), progress on program implementation, the number of anticipated and completed referrals and how many members were lost to follow-up.

ACO pre-interview surveys were collected between March 29 and May 21, 2021. Based on the survey responses, three of the ACO-CBO partnerships operated statewide, while the majority were concentrated in different regions around the state. One outlier ACO had the largest number of member referrals, the greatest percentage of members referred and the largest number of FS programs. It is difficult to point to a single factor driving this volume, however, dedication to FS programing, flexibility and one specific low-touch, high-volume intervention all likely contributed.

ACO Pre-Interview Analysis:

- A handful of ACOs had a high number of programs, but several had only a small percentage of members referred into them at the time.
- Other smaller ACOs had fewer programs, but a greater percentage of members referred to FS programs.
- The percentage of ACO members referred to FS programs ranged from 0.2% to 2.3%.
- The percentage of anticipated versus completed referrals to CBO partners ranged from 20% to more than 100%.
- There was a wide range among ACOs with regard to the percentage of members lost to follow-up. One ACO reported 85% were lost to follow-up.
- There was a near equal distribution of food and housing programs among CBOs.
- Only two ACOs permanently paused any partnerships due to COVID-19.
- The majority of ACOs had at least one new CBO partnership planned for 2022.

ACO	# of FS Programs	# of CBOs	# Food	# Housing	% of Programs Implemented	# of ACO Members Referred	% of ACO Members Referred	% of anticipated referrals	Time from Pos. Screen to Referral	% LTFU
1	3	2	1	2	100%	>500	1.1%	100%	7 days	10.0%
2	5	2	2	3	N/A	362	1.9%	N/A	7-14 days	86.0%
3	12	11	4	0	83%	<100	N/A		48-72 hours	N/A
4	14	20	4	10	93%	3,535	2.3%	~15%	N/A	8.5%
5	3	N/A	1	1	67%	>300	0.9%	100%	~5 days	~5%
6	5	5	3	2	40%	268	0.2%	66%	7-14 days	<10%
7	5	5	2	4	100%	238	0.4%	~20-30%	Variable	>5%
8	13	9	8	5	85%	744	0.5%	N/A	~7 days	N/A
9	1	1	1	0	100%	17	1.0%	~33%	>7 days	0.0%

HCFA received CBO pre-interview progress surveys between March 25 and May 21, 2021. Two CBOs did not complete the survey. All CBOs that submitted the pre-interview survey noted that they engaged in negotiations with more ACOs than they ultimately contracted with. The vast majority had existing relationships with their ACO partners prior to implementing FS partnerships. Two outlier CBOs with the greatest number of member referrals operated nutrition programs, though they differed in their approach to client engagement (e.g. lower touch versus

higher touch). Several CBOs reported temporarily pausing ACO partnerships due to COVID-19, while others fast-tracked partnerships as a result of the pandemic.

CBO Pre-Interview Analysis:

- The number of programs operated by CBOs ranged from one to eight with a relatively even distribution.
- Most CBOs contracted with two ACOs, with one outlier CBO that contracted with 8 ACOs.
- The number of members referred to CBOs ranged very widely as indicated in the ACO analysis.
- The percent of referrals that were successfully engaged was commonly concentrated between 60% and 70%, with one outlier CBO reporting 94% of referrals successfully engaged.

CBO	# of Programs	# of ACOs	# of ACO Members Referred	% of Referrals Successfully Engaged	% LTFU
1	5	2	323	71%	N/A
2	2	1	78	~60%	~39%
3	N/A	2	39	60-70%	25%
4	8	8	1163	70%	N/A
5	1	2	~2000	94%	N/A
6	3	2	107	N/A	N/A
7	*Not Submitted*				
8	2	2	350	70%	N/A
9	*Not Submitted*				
10	2	2	82	65%	20%

MassHealth Policy Recommendations

Based on the findings of this study, HCFA endorses several policy recommendations designed to expand the reach and improve the delivery of supports in the FSP. HCFA recognizes and supports MassHealth's efforts to improve the FSP in their 1115 waiver extension proposal including: enabling flexible services supports at the family level; waiving the in-person requirement for the referral process and incentivizing the collection of race, ethnicity, and language data by ACOs. These proposed changes are supported by the findings of this study and represent critical improvements to the FSP. Additional policy recommendations outlined below should be considered to further strengthen the FSP.

1. **Require minimum ACO panel participation and spending targets in Flex Services.** To increase the reach of the FSP at ACOs with minimal participation, MassHealth should require both a minimum percentage of ACO members to be referred and enrolled in FS

programs and should require a minimum target for ACOs FSP spending. The two-pronged approach would ensure a balance of FS programing that makes interventions available to a wide range of ACO members, while not dis-incentivizing high-intensity, low-enrollment interventions. This can be achieved through the following mechanisms:

a. **Institute minimum panel participation requirements** that require a certain percentage of ACO members to be successfully referred into FS programs. Based on the pre-interview survey findings, we recommend a 2-3% minimum ACO panel enrollment in the FSP. This percentage should be regularly updated based on the most current MassHealth data.
b. **Institute minimum spending requirements** with both a minimum required budget allotment for FSP, and a requirement for ACOs to spend within 25% of the budget allotment. MassHealth should also consider going beyond a 'use it or lose it' clause in ACO FSP contracts to designate ACOs as out of contractual compliance for not meeting the requirement.
c. **Offer additional incentives for housing interventions.** Because they were reported to be more challenging to implement, additional financial incentives for investing in housing supports should be made available to ACOs.

2. **Facilitate coordination and cross-training to enable FS housing programs to access newly available rental assistance funds and assist in completion of applications**. The inability for FSP funds to support payment of back-rent and arrears was cited as a critical bottleneck by ACOs and CBOs. While use of FSP funds for this purpose would be helpful, the current availability of significant rental assistance through state and federal funding makes this unnecessary at this time. However, should the current rental assistance funding dissipate in the coming years, MassHealth should consider allowing FS funds to be used for paying back-rent and arrears. Applications for these funds can be burdensome and FSP housing program staff, if given the appropriate training and resources, could be critical to assisting members with the application process. MassHealth should offer comprehensive education to providers and CBOs alike on the application process for rental assistance. Some of the CBOs already administer rental assistance in their regions and could be a helpful resource to help ACOs and other CBOs more seamlessly address housing.

3. **Streamline eligibility requirements and documentation.** MassHealth should enable additional flexibility in FSP eligibility criteria whenever possible to facilitate broader take-up of interventions and minimize member frustrations, which would help to ensure that members are offered resources or supports if they have a positive HRSN screen. This should include fully relying on staff attestation for documentation of any co-occurring health diagnoses.

4. **Require standards for ACO-based FSP evaluations beyond utilization and cost metrics.** MassHealth should conduct cross ACO evaluations and potentially require all ACOs to conduct their own evaluations utilizing recommended measures of impact. Recommended measures should include intervention impacts on mental health and resilience measures, primary care engagement and changes in food or housing insecurity status in addition to

impacts on utilization and costs. Longer time horizons for measuring impact should also be considered.

5. **Establish data sharing standards** with enhanced support to both ACOs and CBOs to upgrade systems. MassHealth should consider requiring interoperability functionality standards for referral and billing systems utilized for the FSP.

6. **Enable FSP funding models in which funding flows directly to CBOs to partner with ACOs.** One of the overarching challenges cited by CBOs was that ACOs retain the vast majority of the power in the FSP because ACOs "hold" the FSP funds. Re-directing funds directly to CBOs, potentially combined with a hub model for CBO services, would help to address the unequal power dynamics between CBOs and ACOs and create a stronger, higher-functioning FSP.

7. **Develop resources to facilitate and streamline new ACO-CBO partnerships and coordination among existing partners.** This can be accomplished by the use of databases to identify CBOs in an ACO's catchment area that have the capacity and readiness to partner or by providing ACOs a listing of CBOs that have experience participating in the FSP. More opportunities for ACOs and CBOs to meet and share best practices would also be beneficial.

8. **Provide support to CBOs for technical needs.** MassHealth should consider additional rounds of funding for electronic system upgrades within CBOs. Similar to the SSO preparation funds, using a list of recommended vendors as well as a requirement for interoperability would go a long way towards increasing collaboration and data tracking.

9. **Move toward standardized ACO-CBO contracts** that minimize financial risks for CBOs and recognize organizational differences between ACOs and CBOs. ACOs should be encouraged to structure payment to ensure consistent funding for CBOs. Lump-sum payments were found to be particularly helpful to ensure continuous CBO staff capacity.

10. **Broaden covered FSP services and domains** beyond food and housing to address more upstream HRSNs, such as workforce training and education. Allow for longer availability of FSP supports beyond established 3- and 6- month options.