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# The 'Social Vendor' Transformation: Formalizing Community-Based Partnerships in the 2027 D-SNP Framework

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***Abstract-*** ***This paper investigates the evolution of community-based organizations (CBOs) into formalized "social vendors" within the evolving 2027 Dual-Eligible Special Needs Plan (D-SNP) regulatory framework and evaluates the operational, financial, and technological infrastructures necessary for sustainable Medicare-Medicaid integration. Driven by recent mandates from the Centers for Medicare & Medicaid Services, such as exclusively aligned enrolment, improved State Medicaid Agency Contracts, and tiered integration models for HIDE and FIDE SNPs, healthcare delivery is transitioning from fragmented coordination to accountable, value-based, and person-centered systems for dually eligible beneficiaries. This paper employs policy analysis and cross-state implementation evidence to examine the role of Community Care Hubs (CCHs) as essential intermediates that consolidate contracts, standardize payment systems, facilitate data interoperability, and reduce administrative burdens for smaller community-based organizations (CBOs). The article assesses the shift from fee-for-service reimbursement to capitated and value-based payment models, emphasizing their effects on cost containment, financial sustainability, and quality performance in Medicaid managed care and Medicare Advantage structures. Special emphasis is placed on capacity disparities, regulatory obligations, technological integration, and governance frameworks that affect CBO preparedness and equitable involvement in integrated care networks. Findings suggest that strategic procurement, standardized contractual frameworks, targeted infrastructure investment, and interoperable data platforms are crucial for synchronizing social care delivery with healthcare financing and quality assessment systems. The study indicates that sustainable integration relies on stratified technical support, risk-adjusted payment mechanisms, and enhanced state monitoring capacity to balance regulatory accountability with community responsiveness. This report situates CBO vendorization within comprehensive payment and policy changes, offering a scalable implementation roadmap for delivering cost-effective, coordinated, and outcomes-oriented care for dual-eligible populations.***

## I. THE 2027 D-SNP REGULATORY LANDSCAPE: ALIGNMENT MANDATES AND INTEGRATION IMPERATIVES

The Centers for Medicare & Medicaid Services (CMS) established a radical regulatory framework for Dual-Eligible Special Needs Plans (D-SNPs) for Contract Year 2027, fundamentally reshaping the operational and contractual landscape for integrated care (Oluwabanke et al., 2025). This framework is driven by three interrelated mandates: exclusively aligned enrolment criteria, improved State Medicaid Agency Contract (SMAC) provisions, and the establishment of integrated plan models, namely Highly Integrated Dual-Eligible Special Needs Plans (HIDE SNPs) and Fully Integrated Dual-Eligible Special Needs Plans (Barth et al., 2019). The objective of these improvements is to eliminate past fragmentation in care delivery for dually eligible people and to create a strong accountability framework for integrated service provision.

### 1.1 Exclusively Aligned Enrollment Mandates and Operational Restructuring

A fundamental aspect of the 2027 standards is the mandate for exclusively aligned enrolment (EAE). Commencing in 2027, all D-SNPs associated with Medicaid Managed Care Organizations (MCOs) are required to limit new enrolment to persons concurrently enrolled in both the Medicare SNP and the corresponding Medicaid MCO (Garrett, et al., 2025). This requirement, established under the requirements finalized in the Contract Year 2025 rule, requires extensive operational reorganization for health plans, as non-aligned enrolments will be prohibited. The alignment mandate presents considerable implementation difficulties, especially for states required to incorporate these new federal regulations with current Medicaid managed care

agreements and long-term services and supports integration programs (NASEM, 2022).

The effective execution of EAE necessitates that governments modify service-area delineations, oversee complex enrollee transfers, and guarantee continuity of treatment for at-risk populations transitioning between plans. Health plans must concurrently restructure enrolment systems, implement capitated contracts encompassing full Medicare service categories (including behavioral health or long-term services and supports for HIDE SNPs), and devise comprehensive communication strategies for members (Meyer, 2024). CMS has proposed essential flexibility for HIDE SNPs and Coordination-Only D-SNPs in states where Medicaid managed care is not mandatory for dually eligible individuals, permitting these plans to maintain enrolment of full-benefit dually eligible individuals receiving Medicaid through a fee-for-service arrangement (Health Edge, 2025). This adaptability recognizes the varied Medicaid frameworks among states while sustaining the drive for integrated care models.

1.2 Enhanced State Medicaid Agency Contract Requirements and Integration Standards

The 2027 framework reinforces the fundamental importance of State Medicaid Agency Contracts (SMACs). All D-SNPs are required to maintain executed SMACs that comply with designated Medicare-Medicaid integration standards and, for Applicable Integrated Plans (AIPs), consolidated appeals and grievance procedures (MLTSS Association, 2025). The proposed regulation implements substantial changes, including the explicit codification that the loss of a SMAC grants CMS the authority to terminate contracts and elucidates the restrictions on the submission of materials by D-SNP-only contracts (Crowell, 2025).

A notable advancement is CMS's investigation of the potential expansion of SMAC-like criteria to Chronic Condition Special Needs Plans and Institutional Special Needs Plans with substantial populations of dually eligible individuals (CMS, 2024). The study addresses concerns that the substantial increase in C-SNP enrolment may be a deliberate tactic employed by organizations to evade federal and state integration mandates established for D-SNPs. Should this policy be enacted, it would signify a substantial expansion of integration mandates; however, stakeholders such as the Bipartisan Policy Center advocate that any new requirements incorporate appropriate state flexibilities, ample preparation time, and meticulous evaluation of market repercussions to prevent the restriction of beneficiary options (Kelly, 2023).

1.3 HIDE SNP and FIDE SNP Operational Models and Integration Pathways

The 2027 standards establish certain operational models with graduated integration requirements. HIDE SNPs must implement capitated contracts encompassing their whole Medicare service area, including behavioral health or long-term services and supports, with essential compliance measures mandated as early as 2025 (HealthEdge, 2025). FIDE SNPs, denoting the premier integration level, must possess EAE and deliver practically all Medicare and Medicaid benefits via a singular organization or closely affiliated partners.

The proposed regulation also tackles continuity-of-care issues by modifying passive enrolment standards. It suggests substituting the impractical "substantially similar provider network" criterion with a "continuity of care" standard. The new criteria mandates that recipient plans ensure a minimum of 120 days of uninterrupted access to existing providers and demonstrate adequate care coordination staffing capabilities to integrate new members (ATI Advisory, 2025). This modification seeks to activate passive enrolment as a mechanism for preserving integrated coverage after plan terminations, thus reducing disruptive coverage gaps for at-risk beneficiaries.

1.4 Implementation Challenges and State-Level Adaptation

The execution of the 2027 requirements by the state encounters considerable practical and structural obstacles. These include the complex task of reconciling new federal D-SNP regulations with current Medicaid managed care agreements, modifying service-area delineations, overseeing enrollee transitions, and guaranteeing that all SMACs are revised annually to integrate the new stipulations (Health Management Associates, 2025). The primary obstacle frequently recognized is the restricted capacity and knowledge of state personnel in Medicare policy, which impairs the development of long-term

integration strategies and the effective oversight of D-SNP performance (Anthony et al., 2023).

The operational complexity is increased by the necessity to reconcile federal alignment obligations with local flexibility, especially for the enrolment of individuals in Medicaid fee-for-service systems and the prospective regulation of C-SNPs. Effective navigation of this environment necessitates collaborative efforts among federal and state agencies, health plans, and community partners, with a specific focus on beneficiary protections and the creation of sustainable, integrated care models.

## II. FROM INFORMAL PARTNERS TO FORMAL VENDERS: THE CBO TRANSFORMATION JOURNEY

The 2027 federal alignment mandates for Dual-Eligible Special Needs Plans (D-SNPs) require a significant shift in the engagement of Community-Based Organizations (CBOs) with managed care entities, transitioning from informal community partnerships to formal vendor relationships characterized by extensive operational, contractual, and compliance obligations (Crumley et al., 2023). This attempt necessitates CBOs to cultivate advanced administrative infrastructures, execute standardized billing systems, and establish comprehensive compliance frameworks to satisfy the changing requirements of integrated Medicare-Medicaid care delivery models.

### 2.1 Operational Capacity Building and Administrative Infrastructure Requirements

The transition necessitates significant capacity building within community-based organizations, especially in administrative responsibilities that are typically weak in such settings. To facilitate this, states are adopting intermediate models such as state-established Third-Party Administrators (TPAs), Accountable Communities of Health, and Community Care Hubs (CCHs, 2025). These corporations offer essential infrastructural support by consolidating administrative functions, operational infrastructure, and business development (Ayodimeji-Alaba et al., 2025). Their primary functions encompass the allocation of capacity-building or infrastructure funds, the coordination of provider and community-based organization networks, the provision of fiscal services (such as billing and invoicing), the management of reporting to Medicaid agencies, and the delivery of technical assistance regarding Medicaid provider enrolment, business practices, billing, documentation, and reporting requirements (Center of Excellence to Align Health and Social Care, 2024). The operational complexity is especially evident for smaller Community-Based Organizations (CBOs) that lack the financial resources and staffing capacity to autonomously manage the credentialing processes and administrative demands of healthcare entities, a challenge explicitly highlighted in state implementations (CHCS, 2025).

The administrative infrastructure requirement extends to specialized data management and technological tools. Community-based organizations must either install or have access to electronic health record systems, health information exchanges, and standardized screening and referral platforms. For instance, New York's Social Care Networks (SCNs) mandate that Lead Entities furnish onboarding assistance and training to contracted Community-Based Organizations (CBOs), encompassing the configuration and utilization of IT platforms, executing screenings with the standardized Accountable Health Communities (AHC) tool, finalizing eligibility assessments, formulating social care plans, and monitoring referrals and service delivery (NYS DOH, 2025). Similarly, North Carolina's Healthy Opportunities Pilots require Network Leads to utilize the statewide NCCARE360 platform for screening, referral, and sophisticated invoicing operations. This degree of technical sophistication signifies a substantial shift from conventional CBO operations, necessitating synchronized expenditures in technology and personnel training.

### 2.2 Contractual Formalization and Standardized Payment Mechanisms

The contractual transformation entails transitioning from informal agreements to formal vendor contracts that specify service scopes, performance indicators, and payment systems. Four principal payment models have emerged for CBO contracting in healthcare: fixed-price contracts, fee-for-service (FFS) arrangements, bundled payments, and capitation

models (Partnership to Align Social Care, 2023). Each model exhibits specific challenges and risk profiles for CBOs. Fixed-price contracts provide predictability but are unresponsive to fluctuating service requirements. Fee-for-service models may incur substantial administrative expenses for community-based organizations unfamiliar with billing systems and pose the danger of inadequate service volume to offset infrastructure expenditures (Erikson et al., 2025). Bundled payments expose Community-Based Organizations (CBOs) to financial risk if the expenses incurred in serving a customer beyond the set payment amount, necessitating careful episode delineation. Capitation models, characterized by a fixed per-member-per-month (PMPM) payment, involve significant risk around service volume and necessitate comprehensive data analysis for precise rate determination (Okunuga, 2025).

The 2027 D-SNP standards introduce additional contractual difficulties that extend to CBO vendors. A key requirement mandates that all D-SNPs associated with Medicaid Managed Care Organizations must function under Exclusively Aligned Enrolment (EAE), hence prohibiting non-aligned enrolments (KFF, 2025). This requires substantial operational reorganization for health plans, thus impacting their contracted community-based organization networks. Moreover, Highly Integrated Dual-Eligible Special Needs Plans (HIDE SNPs) are required to form capitated contracts that encompass their complete Medicare service area, inclusive of behavioral health and long-term services and supports (McCormack et al., 2025). For community-based organizations delivering these services, this indicates the formalization of vendor partnerships and service contracts to guarantee extensive coverage within a capitated framework.

2.3 Compliance Infrastructure and Technical Assistance Frameworks

Establishing a resilient compliance infrastructure constitutes a major barrier in the CBO transformation process. This includes data privacy, security, and regulatory compliance obligations. A significant obstacle is that community-based organizations (CBOs) offering solely health-related social needs (HRSN) services frequently do not qualify as HIPAA-covered entities; however, they must adhere to intricate data protection regulations when collaborating with healthcare organizations, resulting in a complicated compliance environment (Center for Health Care Strategies, 2023b). The compliance requirements encompass rigorous documentation standards; for example, Community-Based Organizations (CBOs) obtaining capacity-building funds in initiatives such as New York's SCNs are mandated to retain receipts, records, and financial documents for six years following the calendar year in which the funds were received (Center for Health Care Strategies, 2023a).

Technical assistance frameworks are essential elements of effective transformation. Governments and implement organizations offer organized support structures to assist Community-Based Organizations in maneuvering through this complex landscape. These frameworks encompass extensive onboarding and training programs addressing IT platform configuration and screening tool deployment. The provision of specific capacity-building expenditures for personnel wages, equipment, technology, and operational requirements is also included, shown by North Carolina's $100 million investment in infrastructure and community-based organization capacity development (Center for Health Care Strategies, 2023a). Additionally, states create and disseminate standardized contractual templates and model agreements for CBO-MCO and CBO-CCH contracts to facilitate the legal process. Comprehensive data governance and privacy training is delivered to guarantee adherence to state and federal regulations.

2.4 Transformation Challenges and Strategic Adaptation

The transformation process entails numerous persistent, systemic obstacles. Disparities in power between larger healthcare organizations and smaller community-based organizations hinder contract talks, as CBOs frequently lack the legal and financial acumen to secure advantageous terms. Divergent organizational cultures exacerbate integration challenges, as healthcare entities and community-based organizations (CBOs) function with distinct agendas, terminology, and operational frameworks (Center for Health Care Strategies, 2023b). Financial sustainability is a significant issue, especially for

smaller community-based organizations (CBOs) that may not possess the initial resources required to invest in essential infrastructure prior to obtaining contracts, a deficiency that state models seek to remedy through upfront investment (National Academy for State Health Policy, 2024).

The proposed regulatory modifications for 2027 impose supplementary adaptation requirements that directly affect CBO operations. The CMS suggests further flexibility for D-SNP enrolment in states with Medicaid fee-for-service populations and revisions to passive enrolment criteria to guarantee continuity of treatment (ATI Advisory, 2025). The proposed regulation would substitute the "substantially similar" provider network requirement with a continuity of care standard, mandating receiving plans to ensure a minimum of 120 days of continued access to existing providers and services, as well as to exhibit adequate care coordination staffing capacity. For CBOs, this entails cultivating competencies to facilitate smooth member migrations and guarantee service continuity amid enrolment modifications, so introducing additional operational complexity and emphasizing the necessity for formalized, dependable vendor partnerships.

Strategic adaptation for Community-Based Organizations necessitates the formulation of multifaceted strategies. This encompasses diversification of company models to mitigate reliance on singular funding sources and investment strategies in technology that reconcile urgent requirements with long-term scalability. Developing partnerships with other community-based organizations to achieve economies of scale and distribute administrative responsibilities is a realistic method, as demonstrated by "ground-up" models in which established CBOs serve as parent entities for others (National Academy for State Health Policy, 2024). Ongoing advocacy efforts to shape equitable policy formulation and contracting standards are crucial, as is the internal development of the workforce to enhance proficiency in healthcare contracting, compliance, and data management (Center for Health Care Strategies, 2023b). The changing regulatory environment, including CMS's consideration of expanding State Medicaid Agency Contract (SMAC) requirements to additional Special Needs Plans, indicates that the shift towards formal vendor agreements will intensify (Centers for Medicare & Medicaid Services, 2025). Community-Based Organizations must consequently cultivate both operational competencies and strategic insight to adeptly manage this intricate shift while upholding their fundamental aim of assisting vulnerable populations.

## III. COMMUNITY CARE HUB MODELS: OPERATIONAL INFRASTRUCTURE FOR INTEGRATED SERVICE DELIVERY

The impending 2027 D-SNP alignment rules necessitate that Dual-Eligible Special Needs Plans establish formal community partnerships, shifting from informal cooperation to organized vendor agreements. Community Care Hub (CCH) models have emerged as the essential operational framework to facilitate this "social vendor" change (Partnership to Align Social Care, 2022). These foundational organizations consolidate administrative functions, optimize contracting processes, and establish standardized interfaces among community-based organizations (CBOs), health systems, and Managed Care Organizations (MCOs), effectively tackling the operational complexities arising from new integration requirements (Kunkel and Lackmeyer, 2024).

### 3.1 Core Operational Functions of Community Care Hubs

CCHs perform a standardized set of functions that enable CBOs to operate as formal vendors within integrated care models. These core functions include:

*Centralized Contracting and Payment Processing:* CCHs serve as a single point of contact, engaging directly with MCOs and overseeing sub-contracts with a network of CBOs. This framework streamlines what would otherwise constitute a complex web of bilateral agreements (Pencer et al., 2025). Payment systems typically entail per member per month (PMPM) disbursements from Managed Care Organizations (MCOs) to the Community Care Hub (CCH), which subsequently allocates funds to Community-Based Organizations (CBOs) according to state-established fee schedules, bundled payments, or cost-based reimbursement (Crumley et al., 2023).

*Network Development and Quality Management:* CCHs are tasked with establishing and managing

regional networks of service providers, guaranteeing the incorporation of various, frequently smaller, locally based community-based organizations (Yasmin et al., 2022). They offer technical support, implement quality enhancement initiatives, and evaluate CBO performance to ensure program fidelity throughout the network.

*Standardized Screening and Referral Coordination*: CCHs facilitate the utilization of standardized screening instruments for health-related social needs (HRSN), including state-specific social determinants of health (SDOH) tools or the CMS Accountable Health Communities (AHC) Screening Tool (Billioux et al., 2017). They oversee the referral process between healthcare providers and community-based organizations, guaranteeing prompt service provision and follow-up.

*Data Infrastructure and Reporting:* Robust data systems are crucial for CCH operations. These systems provide safe data exchange, extensive data collecting, and reporting to assess network performance, illustrate efficacy, and fulfil compliance obligations (Nowrozy, 2024). States may establish centralized platforms (e.g., North Carolina's NCCARE360) or permit adaptable platforms that integrate into a statewide health information network (e.g., New York's SHIN-NY) (Drake et al., 2024)

*Governance and Stakeholder Engagement*: Effective CCHs build governing boards that encompass broad representation, including CBOs, healthcare providers, community advocates, and current or past Medicaid beneficiaries, to guarantee community-driven planning and oversight (Center for Health Care Strategies, 2025).

3.2 State-Specific Implementation Models

State Medicaid programs have developed distinct CCH models, each with unique operational structures. *New York:* New York's Social Care Networks (SCNs), established under a 1115 waiver amendment, are supported by Lead Entities (LEs) that are required to become Medicaid billing providers (Haas, 2025). The state utilizes a flexible technological strategy, enabling local entities to develop or acquire their own screening and referral systems, contingent upon their integration of data into the Statewide Health Information Network for New York. New York offers standardized contracts for LE-MCO and LE-CBO agreements and requires the utilization of a uniform AHC Screening Tool. The concept emphasizes smaller Community-Based Organizations (CBOs) by instructing Local Entities (LEs) to distribute capacity-building money to organizations with operating budgets below $5 million (CalOptima Health, 2024).

*North Carolina:* Healthy Opportunities Pilots (HOP) Initiated as a component of the state's Medicaid managed care transition, North Carolina's HOP model utilizes a prescriptive methodology. The state competitively appoints Network Leads (NLs) and typically excludes Managed Care Organizations and large healthcare systems from fulfilling this function (Van Stekelenburg et al., 2025). The concept requires the utilization of a singular statewide platform, NCCARE360, for screening and referrals, and functions according to a comprehensive fee schedule for 29 approved services.

*California:* Under the Cal AIM initiative, Community Care Hubs (CCHs) have developed organically to enable contracting between Medi-Cal Managed Care Plans and Community-Based Organizations (CBOs) that offer services such as Enhanced Care Management and Community Supports (Kelly, 2022). The concept comprises many lead organizations, including nonprofit entities, counties, and independent physician groups. An illustration is the Kaiser Foundation Health Plan's implementation of a formal Request for Proposal (RFP) procedure to engage Network Lead Entities, who manage Community-Based Organization provider networks, while the Managed Care Plan (MCP) retains responsibility for the overarching contract and quality (Kaiser Permanente, 2024).

3.3 Alignment with 2027 D-SNP Operational Requirements

The infrastructure offered by CCHs immediately facilitates adherence to essential 2027 D-SNP mandates, which require substantial operational reorganization, including exclusively aligned enrolment (EAE) for all D-SNPs associated with Medicaid MCOs (HealthEdge, 2025). The subsequent table demonstrates the correlation between D-SNP requirements and CCH support functions:

| D-SNP Requirement | CCH Support Function | Operational Rationale |
|---|---|---|
| Exclusively Aligned Enrollment (EAE) | Centralized member screening, eligibility verification, and enrollment coordination. | Streamlines the complex process of ensuring simultaneous Medicare and Medicaid enrollment, a requirement for all affiliated D-SNPs by 2027. |
| State Medicaid Agency Contract (SMAC) Compliance | Standardized contracting templates and centralized payment processing. | Ensures consistent contractual terms and financial flows between MCOs and multiple CBOs, formalizing the vendor relationship. |
| Care Coordination Staffing Capacity | Network management, technical assistance, and quality oversight. | Provides a scalable infrastructure to onboard new members and meet enhanced care coordination demands, as highlighted in proposed passive enrollment criteria. |
| Continuity of Care (e.g., 120-day standard) | Referral management and service coordination across a provider network. | Maintains member access to current providers and services during plan transitions, a key update in the CY2027 proposed rule. |

The proposed CY2027 regulation introduces particular operational flexibilities, permitting HIDE and Coordination-Only D-SNPs to enroll beneficiaries in Medicaid fee-for-service in designated states, and substitutes the "substantially similar" network criterion for passive enrolment with a continuity of care standard mandating 120-day access (ATI Advisory, 2025). CCHs, with their established networks and standardized procedures, are fundamentally equipped to implement these standards efficiently.

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3.4 Funding Models and Sustainability

CCH models incorporate diverse funding mechanisms critical for sustaining the formalization of CBOs:

Infrastructure and Capacity Building Grants: State funding is allocated for administrative expenses, information technology systems, and personnel capacity. North Carolina's HOP allocates a significant percentage of its waiver funding for this reason (Marple and Maria, 2024).

Performance-Linked Payments: Models such as New York's SCNs enable Lead Entities to acquire supplementary infrastructure funding based upon performance measures, thereby incentivizing quality and outcomes.

Standardized Reimbursement Schedules: State-established pricing schedules for HRSN services ensure payment predictability and alleviate administrative burdens in claims processing for both CCHs and CBOs (Crumley et al., 2023).

Value-Based Payment (VBP) Linkages: CCH models are progressively structured to correspond with extensive VBP programs, wherein payments are linked to the attainment of quality standards and the provision of efficient care (Leao, 2025).

3.5 Implementation Challenges and Considerations

Successful CCH implementation requires navigating several operational challenges evident in state experiences:

Technology Integration: The trade-off between standardization and local adaptability arises from balancing the efficiency of a mandated single platform, as exemplified by North Carolina, with the flexibility of various integrated systems, as seen in New York.

CBO Readiness and Support: Smaller Community-Based Organizations frequently lack the technological and administrative capabilities necessary for Medicaid contracting. Thorough onboarding, training, and continuous technical support are crucial, as emphasized by the necessity for "CBO readiness guides".

Data Interoperability and Governance: Aggregating data from several platforms while maintaining adherence to privacy regulations necessitates substantial coordination, uniform coding, and comprehensive data-sharing agreements.

Equitable Governance: Facilitating substantial involvement of Medicaid beneficiaries and smaller community-based organizations in CCH governing boards continues to be a persistent difficulty, notwithstanding state mandates for such representation.

- Community Care Hub models constitute the fundamental operational basis for the 2027 D-SNP initiative. By centralizing administrative operations, standardizing contracts and payments, and establishing scalable networks, CCHs facilitate the transformation of CBOs into formal, integrated suppliers. This transition is essential for plans to comply with federal alignment standards while providing community-responsive, coordinated care to dual-eligible individuals.

## IV. FUNDING MODELS AND PAYMENT MECHANISMS: FROM FEE-FOR-SERVICE TO VALUE-BASED ARRANGEMENTS

The incorporation of Community-Based Organizations (CBOs) as integrated vendors within the 2027 D-SNP framework necessitates a major transformation in funding and payment mechanisms. This transition progresses from basic fee-for-service (FFS) models to advanced value-based payment (VBP) frameworks that synchronize community-based organization (CBO) compensation with the primary objective of enhancing health outcomes for dual-eligible beneficiaries (Figueroa et al., 2025). The financial sustainability of these collaborations relies on sufficient payment rates, strategic infrastructure expenditures, and the establishment of performance indicators that reliably connect CBO services to quantifiable enhancements in care coordination and member health.

### 4.1 Traditional Payment Models and State Fee Schedules

Initial financial stability for Community-Based Organizations (CBOs) is frequently facilitated by conventional payment systems, which act as a transition to more sophisticated value-based models. These encompass fixed-price contracts, providing predictability for pilot initiatives, and fee-for-service arrangements that enable service volume to align with varying member requirements (Glassberg et al., 2025). The establishment of state-standardized fee schedules is a significant advancement, ensuring uniform reimbursement and minimizing administrative complexity across regions. North Carolina's Healthy Opportunities Pilots (HOP) function according to a comprehensive fee schedule created in collaboration with CMS, outlining specified services, durations, payment units, and rate limits (Van Vleet, 2024). Likewise, New York's Social Care Networks (SCNs) require Lead Entities (the state's equivalent of Community Care Hubs) to compensate CBOs according to state-established fee schedules, ensuring consistency and financial predictability for community providers. This standardization is essential for the expansion of CBO integration and corresponds with the requirement for transparent, manageable contracting in accordance with the 2027 D-SNP regulations.

### 4.2 Capitated and Per Member Per Month (PMPM) Arrangements

A notable development is capitated payment models, providing CBOs predictable sources of income and encouraging effective population-based care management (Adeseun et al., 2025). These approaches cover the expenses of services for a population that qualifies by providing a fixed payment per member per month (PMPM) (Edmiston, 2022). Capitated contracts for Highly Integrated D-SNPs covering their whole Medicare service area, including behavioral health and long-term services and supports, are required by the 2027 D-SNP regulations, which makes this strategy more important (Integrated Care Resource Center, 2025). The PMPM model is operationalized in jurisdictions such as New York, where network CBOs get funding from Managed Care Organizations (MCOs) that pay a state-defined PMPM rate to SCN Lead Entities (Community Health Care Association of New York State, 2024). By establishing distinct beneficiary groups with combined Medicare and Medicaid coverage, the concurrent requirement for solely aligned enrolment by 2027 strengthens

capitation and makes risk management and financial forecasting easier for plans and CBO vendors.

4.3 Strategic Infrastructure and Capacity Building Funding

Substantial initial investment in infrastructure is crucial to surmount the considerable administrative and technological obstacles that have traditionally marginalized Community-Based Organizations from formal healthcare collaborations. In response, state Medicaid programs are designating specific funding for capacity enhancement. A notable instance is North Carolina's HOP initiative, which allocated 100 million of its 650 million budget explicitly for infrastructure development and community-based organization capacity building, with half of that amount mandated to be directed to community organizations (North Carolina Department of Health and Human Services, 2025). These funds are allocated for vital manpower, administrative systems, IT enhancements, and training, critical elements that equip CBOs to fulfil the strict standards of healthcare contracting, encompassing data reporting, quality assessment, and adherence to rules such as HIPAA. The SCN program in New York utilizes a comparable framework, offering infrastructure funding to Lead Entities depending upon regional Medicaid enrolment and service expenditures, while allowing for the allocation of resources towards CBO technical assistance and system improvement (Center for Health Care Strategies, 2023). This strategic initiative tackles the fundamental operational difficulties encountered by smaller CBOs and is essential for their evolution into sustainable vendors.

4.4 The Transition to Value-Based Payment and Performance Incentives

The most advanced development in CBO finance is the incorporation into value-based payment (VBP) models that directly associate reimbursement with health outcomes and quality criteria. States are implementing performance-based incentives to facilitate this shift. The SCN model in New York permits Lead Entities to obtain supplementary infrastructure funding up to 10% in the second year and 15% in the third year, depending on their success relative to targets set from baseline data (Center for Health Care Strategies, 2023). This establishes a direct financial motivation for enhancing quality while mitigating the administrative expenses associated with implementing VBP frameworks. The expansive Medicaid Value-Based Purchasing framework presents various models pertinent to Community-Based Organization (CBO) collaborations, each characterized by unique procedures and consequences for risk-sharing.

| VBP Model | Core Mechanism | Relevance to CBO Vendorization |
|---|---|---|
| Pay for Performance | Bonus payments for achieving specific quality or outcome measures. | Can be layered atop other payment models to align CBO activities with plan objectives for dual-eligible members. |
| Shared Savings | Providers receive a portion of savings achieved when care costs fall below a risk-adjusted target while maintaining quality. | Suitable for CBOs whose services demonstrably reduce healthcare utilization and total cost of care for attributed populations. |
| Bundled Payments | A single, comprehensive payment for an "episode of care" or a defined suite of services. | Appropriate for complex, multi-component services delivered over time, such as intensive care management or housing support programs[6]. |
| Capitation/PMPM | Fixed periodic payment per beneficiary to cover a defined set of services. | Provides financial predictability and incentivizes efficient, preventive care; aligns with D-SNP service area requirements. |
| Outcome-Based Payment | Payment is contingent on a client reaching a predefined, measurable outcome. | Directly ties CBO reimbursement to concrete member improvements, such as stable housing or improved nutrition. |

4.5 Directed Payments and State Contracting Leverage
Directed payment arrangements serve as a powerful state mechanism to guarantee sufficient compensation and promote particular policy objectives within Medicaid managed care. State laws mandate that MCOs compensate providers based on designated methodologies, which may involve establishing minimum fee schedules or mandating participation in value-based payment schemes (Dindi, 2024). The absence of specific applicability to CBOs in the offered information notwithstanding, this mechanism affords governments direct influence in shaping the financial framework for integrated care. The authority is enhanced by the 2027 D-SNP criteria for State Medicaid Agency Contracts (SMACs), enabling states to impose specific payment structures and performance standards on CBO suppliers. This leverage is set to increase, as CMS is currently investigating the potential implementation of SMAC-like requirements for Chronic Condition SNPs (C-SNPs) and Institutional SNPs (I-SNPs) that enroll significant numbers of dually eligible individuals, thereby further formalizing the vendor relationship for community providers within special needs plans (Centers for Medicare & Medicaid Services, 2025).

4.6 Quality Measurement, Reporting, and Financial Sustainability
The establishment of reliable performance measurements is essential for CBOs functioning within value-based frameworks. The upcoming Medicaid and CHIP Quality Rating System (MAC QRS), which states are required to implement by December 2028, outlines a fundamental set of 16 obligatory quality metrics (Virginia Department of Medical Assistance Services, 2025). It is essential that these measures be categorized by dual eligibility status, establishing a clear framework for assessing the success of plans and, by extension, vendors, specifically for the dually eligible population. Data from state pilots corroborates the feasibility of this measurement. The study of North Carolina's HOP indicated that participants saw a decrease in emergency department visits and, for specific demographics, a reduction in inpatient hospitalizations, leading to an estimated savings of around $85 per enrollee monthly (Berkowitz, 2025). The Community Care Hub (CCH) model has evolved as a vital support structure to mitigate the financial risk and administrative complexity linked to VBP models, particularly for smaller CBOs. Hubs centralize contracts, payment processing, data reporting, and offer technical help, thus diminishing transaction costs and facilitating the involvement of a diverse network of community-based organizations in integrated care delivery that would otherwise be logistically unfeasible (Brazie, 2026).

## V. DATA INFRASTRUCTURE AND QUALITY MEASUREMENT: ENABLING PERFORMANCE AND ACCOUNTABILITY

The integration of Community-Based Organizations (CBOs) as vendors within the 2027 D-SNP framework requires an advanced technology infrastructure that facilitates standardized screening, efficient data interchange, and comprehensive performance monitoring (HealthEdge, 2025). This change necessitates that Community-Based Organizations (CBOs) progress from informal partners to official suppliers, equipped with documented interoperability, data reporting capabilities, and quality measurement systems that comply with Centers for Medicare & Medicaid Services (CMS) standards. The operational transition necessitates the establishment of statewide platforms, uniform screening instruments, secure data sharing protocols, and quality measures that facilitate performance accountability and value-based payment incentives.

5.1 Standardized Screening and Referral Platforms: The Foundation of CBO Integration
The incorporation of Community-Based Organizations (CBOs) into Dual-Eligible Special Needs Plan (D-SNP) service delivery frameworks relies essentially on standardized screening instruments and referral systems that allow for the systematic identification of health-related social needs (HRSN) and promote efficient linkages to suitable community services. State Medicaid programs have employed varied strategies for platform deployment. North Carolina requires the utilization of NCCARE360, a statewide centralized platform developed by Unite Us, which includes advanced features for billing, payment processing, and eligibility assessment exclusively for its Healthy Opportunities Pilot (HOP) Network Leads (Huber et

al., 2023). This platform incorporates North Carolina's standardized social determinants of health (SDOH) screening tool, emphasizing four essential domains: food insecurity, transportation access, housing/utilities stability, and interpersonal violence.

in contrast, New York has adopted a more adaptable strategy via its Social Care Networks (SCNs), permitting Lead Entities (the state's designation for Community Care Hubs) to develop or acquire their own screening and referral systems (such as Unite Us, Find Help, Channel 360, and Together Now). These systems supply data to the Statewide Health Information Network for New York (SHIN-NY), facilitating extensive statewide data aggregation and interchange (Sachs Policy Group, 2024). New York mandates that HRSN providers employ the state's standardized version of the CMS' Accountable Health Communities (AHC) Screening Tool, which evaluates needs across various domains such as housing, food security, transportation, employment, education, and interpersonal safety (Fennelly et al., 2025). The contrasting approaches reflect the conflict between standardization for uniformity and flexibility for local customization, with both frameworks indicating that effective CBO integration necessitates a strong technology infrastructure for screening, referral management, and service coordination.

5.2 Interoperability Standards and Data Exchange Protocols

The conversion of CBOs to official vendors inside D-SNP frameworks demands advanced interoperability standards that facilitate secure data transmission among diverse healthcare and community service systems. New York's SHIN-NY functions as a central repository, facilitating the integration of referral and social care demand data from many systems into a unified statewide data warehouse. Healthcare providers may perform screenings within their Electronic Health Record (EHR) systems and relay data via SHIN-NY to the corresponding SCN platforms (Chukwu, 2024). The complexity of interoperability is heightened by the necessity for standardized coding systems; New York established extensive standardized codes for all screenings and services to enhance data tracking and aggregation across various Social Care Networks (Ezeh et al., 2023).

The technological specifications encompass not just data interchange but also secure authentication mechanisms, consent management systems, and privacy safeguards that adhere to rules such as HIPAA. This poses significant implementation difficulties for smaller community-based organizations with restricted technology expertise. Consequently, states are obligated to furnish substantial assistance; for instance, North Carolina and New York promote CCHs to collaborate with smaller, under-resourced CBOs, with New York instructing its Lead Entities to prioritize CBOs with operational budgets below $5 million.

5.3 Quality Measurement Systems Aligned with CMS Requirements

The establishment of CBO partnerships requires quality measurement tools that comply with CMS reporting standards and accurately reflect the distinct impact of community-based services on health outcomes. The Medicaid and CHIP Quality Rating System, required to be implemented by December 31, 2028, establishes a fundamental structure (Kearly et al., 2025). States must incorporate a CMS-defined initial mandatory set of 16 quality metrics, with ratings categorized by race and ethnicity, gender, and dual eligibility status, a stipulation especially relevant for D-SNP beneficiaries. Medicare Advantage D-SNPs that just offer Medicaid coverage for Medicare cost-sharing are exempt from MAC QRS; however, the stratification rule guarantees concentrated attention on dual-eligible patients within wider managed care quality initiatives (Anthony et al., 2023). State Medicaid agencies are developing performance-based payment models associated with these quality metrics. Entities leading New York's Social Care Network may get up to 10% of infrastructure funding in the second year and 15% in the third year, based on performance, and use baseline data from the first year to set future targets. North Carolina's HOP has exhibited statistically significant effects, with assessments indicating a reduction of around $85 per HOP enrollee monthly on combined medical and HOP services, as well as decreases in emergency department visits and inpatient hospitalizations (Berkowitz et al., 2025). These outcomes-based assessment methodologies correspond with CMS's overarching transition to value-based care, establishing financial incentives for

D-SNPs to proficiently include CBO services that tackle social determinants of health.

### 5.4 Technology Infrastructure Support and Implementation Challenges

The magnitude of technical transformation necessary for the formalization of CBOs poses considerable challenges, especially for smaller CBOs with limited finances and technological capabilities. The rapid growth of statewide platforms such as NCCARE360 has exposed challenges in training diverse community-based organizations with differing levels of technological proficiency and in customizing platforms to address the specific requirements of healthcare organizations, health plans, and community providers (Jishaant and Chowdhury, 2023). To mitigate these challenges, states offer infrastructure and capacity-building assistance. Infrastructure funds may be allocated for essential personnel, administrative expenses, information technology systems, and capacity-building initiatives for community-based organizations, including training community providers to perform services and process payments. States create CBO preparedness manuals and appoint local technical assistance providers who comprehend community dynamics and can deliver specialized support for data collecting, sharing, and compliance obligations (Crumley et al., 2023).

### 5.5 Governance and Continuous Improvement Frameworks

Robust governance frameworks are essential for effective data infrastructure and quality measurement systems, ensuring accountability, transparency, and ongoing enhancement. North Carolina requires HOP Network Leads to assemble governing bodies that include varied representation from health and social care sectors, such as health systems, local health departments, behavioral health providers, federally qualified health centers, and consumer advocates, with a minimum of one member having expertise in evaluation and data management (Johnson, 2024). New York mandates that SCN Lead Entities construct oversight boards with 51% representation from Community-Based Organizations, alongside healthcare clinicians, community advocates, and a minimum of two current or past Medicaid beneficiaries utilizing HRSN services (Community Health Care Association of New York State, 2024). Continuous improvement models integrate both rapid-cycle assessments and long-term evaluations. North Carolina employs rapid-cycle assessments to acquire real-time data, facilitating prompt program adjustments alongside thorough annual evaluations (Chaplowe, 2024). The Health Equity Regional Organization (HERO) effort in New York functions as a statewide coordinator that examines patient and service data to identify regional deficiencies, evaluate data capabilities, offer technical assistance, and measure success metrics pertaining to Social Care Networks (Sachs Policy, 2024). The governance and enhancement procedures establish critical feedback loops for the ongoing refining of CBO integration models, assuring conformity with increasing D-SNP standards and community demands.

The technological prerequisites for CBO formalization within the 2027 D-SNP framework signify a transformative change in healthcare data infrastructure, necessitating advanced platforms, standardized protocols, and extensive quality measurement systems that integrate clinical care with community services. Success hinges on reconciling standardization for uniformity with flexibility for local adaptation, while guaranteeing fair participation through focused capacity-building and technical support for community organizations aiding vulnerable groups.

## VI. IMPLEMENTATION CHALLENGES AND POLICY RECOMMENDATIONS FOR SUSTAINABLE INTEGRATION

The integration of Community-Based Organizations (CBOs) as formal vendors within the 2027 Dual-Eligible Special Needs Plan (D-SNP) framework introduces significant operational and financial problems. The regulatory transition to exclusively aligned enrolment (EAE) and more strict integration requirements establishes a crucial framework for accountability, yet it also reveals considerable disparities in organizational capacity, technological preparedness, and financial viability between conventional healthcare organizations and community-based partners (HealthEdge, 2025). Confronting these issues is essential for achieving the policy objective of integrated, person-centered care for dual-eligible individuals and necessitates a

synchronized array of policy actions at the federal, state, and plan levels.

6.1 Capacity Disparities and Organizational Readiness
A principal obstacle to formalization is the significant capacity disparity between established Managed Care Organizations (MCOs) and numerous Community-Based Organizations (CBOs), especially smaller entities with constrained financial resources. These community-based organizations frequently lack the administrative framework, specialized personnel, and expertise necessary to manage complex Medicaid contracting, credentialing procedures, and the compliance obligations inherent in State Medicaid Agency Contracts (Kunkel and Lackmeyer, 2024). The power imbalance in negotiations is worsened by information asymmetry, wherein Community-Based Organizations may lack access to critical data on reimbursement benchmarks or performance expectations. This challenge is made worse at the state level, where Medicaid agencies may possess limited staffing capacity and experience in Medicare integration, impeding their ability to effectively monitor D-SNP performance and enforce SMAC provisions (Medicaid and CHIP Payment and Access Commission, 2025). The 2027 need for all D-SNPs associated with Medicaid MCOs to implement EAE introduces additional operational complexity, necessitating that CBOs concurrently modify enrolment systems and care coordination processes.

6.2 Technological and Data Integration Barriers
Successful integration depends on strong data exchange; nevertheless, many community-based organizations function with inadequate technology infrastructure. They often encounter difficulties with the upgrades required for electronic health record (EHR) interoperability, secure health information exchange, and the data analytics essential for value-based contracting and quality reporting (National Academy for State Health Policy, 2024). The technical gap is especially pronounced for Community-Based Organizations (CBOs) that serve rural or marginalized populations. The suggested continuity-of-care requirement for passive enrolment mandates that D-SNPs give a minimum of 120 days of uninterrupted access to a beneficiary's existing providers, highlighting the imperative for efficient data sharing, a capability that some CBOs do not possess (ATI Advisory, 2025). Moreover, governments utilize diverse strategies for data infrastructure, ranging from mandatory statewide platforms such as North Carolina's NCCARE360 to more adaptable models for community-based organizations to choose their own systems, potentially resulting in interoperability issues between jurisdictions and programs.

6.3 Contracting Complexities and Unsustainable Payment Models
The transition from informal referrals to formal vendor contracts entails considerable difficulty. Community-Based Organizations must traverse a range of payment structures, each characterized by unique administrative challenges and financial risk profiles. Prevalent methods include fee-for-service (FFS), characterized by administrative complexity yet minimal financial risk for the Community-Based Organization (CBO); bundled payments, which promote efficiency while presenting moderate risk; and capitation, which ensures payment predictability but imposes significant financial risk on the provider. Smaller Community-Based Organizations frequently lack the financial reserves and actuarial proficiency necessary to undertake the risks associated with capitated or bundled payments, so confining them to less sustainable Fee-for-Service arrangements (Ageing and Disability Business Institute, 2023). The lack of standardized contract templates and consistent payment terms among states and MCOs increases the transactional costs and complexities for CBOs attempting to collaborate with various plans.

6.4 Policy Recommendations for a Sustainable Ecosystem
To overcome these barriers and foster successful, long-term CBO integration, a multi-layered policy strategy is essential.
1. Invest in Tiered Capacity-Building and Technical Assistance: States and CMS ought to create specific financial mechanisms for the capacity development of community-based organizations, with an emphasis on small to midsize entities. This support must encompass administrative infrastructure, personnel training in Medicaid billing and compliance, and continuous technical assistance. Effective state models offer a framework: Healthy Opportunities in North Carolina Pilots designated significant infrastructure funding to Network Leads for the development and

support of CBO networks, but Massachusetts' community-oriented "Parent Entity" model enables seasoned CBOs to consolidate administrative duties for smaller affiliates (National Academy for State Health Policy, 2024). Federal advice should promote the implementation of these models, ensuring resources are customized to meet local organizational requirements.

2. Standardize and Simplify Contracting Frameworks: The Centers for Medicare & Medicaid Services, in partnership with states, ought to create and distribute standard contract templates for Managed Care Organization-Community-Based Organization agreements. These templates must provide explicit, consistent terminology for data sharing, liability, and performance evaluation to mitigate negotiation friction and power disparities (Center for Health Care Strategies, 2023b). Accompanying guidance should delineate graduated payment pathways, enabling CBOs to commence with lower-risk models (e.g., cost-based reimbursement or fixed-price contracts for pilots) and progress to value-based arrangements as their data and financial management competencies advance (Ageing and Disability Business Institute, 2023).

3. Fund Technology Infrastructure and Promote Interoperability: Grants designated for technological adoption are essential. Funding must facilitate Community-Based Organizations' access to integrated screening and referral platforms, electronic health record interfaces, and secure data exchange capabilities that adhere to applicable privacy regulations (National Academy for State Health Policy, 2024). Policymakers must prioritize investments in interoperable systems and promote the integration of social service data standards inside health information networks to guarantee community-based organizations may be linked participants in the care continuum.

4. Develop Sustainable, Value-Based Funding Streams: States should collaborate with CMS to establish sustainable reimbursement systems for Health-Related Social Needs (HRSN) services, moving beyond pilot-dependent funding. This entails the formulation of Medicaid state plan changes or waivers that delineate explicit authority and payment mechanisms. Payment models must incorporate suitable risk adjustment for the populations served and allocate resources for the essential infrastructure and care coordination that support effective service delivery, rather than solely focusing on isolated interventions (Center for Health Care Strategies, 2023a).

5. Enhance State Agency Support and Alignment: CMS ought to enhance technical support for state Medicaid agencies, especially those with limited experience in Medicare integration. This assistance should concentrate on SMAC implementation, D-SNP supervision, and the formulation of long-term strategies that match with Medicaid and Medicare policy goals (Medicaid and CHIP Payment and Access Commission, 2025). Enhancing state capacity is essential for the successful implementation of federal integration mandates into practical partnerships.

By executing these specific proposals, stakeholders may establish a supportive ecosystem that recognizes the essential role of CBOs while equipping them with the necessary tools, resources, and equitable contractual frameworks to succeed as official partners within the integrated 2027 D-SNP environment.

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