Advancing Partnerships: Contracting between Community-based Organizations and Health Care Entities

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Background

The impact of community-based organizations (CBOs) in population health, individual well-being and health, and health expenditures is receiving increasing attention. CBOs such as Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) coordinate and deliver services including nutrition, safe housing, and access to transportation that address needs and risks related to the social determinants of health (SDOH). Through cross-sector collaboration across the health and social services sectors, these services can improve health outcomes and system-level effectiveness. For example, recent research has shown that cross-sectoral partnerships and specific services offered by AAAs reduce Medicare expenditures (Brewster et al., 2018), avoidable nursing home placement (Brewster et al., 2021), and social isolation (Thomas and Dosa, 2015).

Building on this foundation provided by CBOs in their communities, health care entities and CBOs are working collaboratively for more effective and efficient inclusion of social supports into integrated care systems. Contractual partnerships between health care entities and CBOs are a critical component of care integration.

With continued funding from The John A. Hartford Foundation, the Administration for Community Living (ACL), and The SCAN Foundation, the Aging and Disability Business Institute (Business Institute), led by USAging (formerly the National Association of Area Agencies on Aging), supports business acumen capacity-building for CBOs to enhance contracting with health care partners.

The Business Institute began its work in 2016; those efforts have been documented and assessed by Scripps Gerontology Center at Miami University, the independent evaluator for the project. An important component of the evaluation is a Request for Information (RFI) survey that has been conducted in 2017, 2018, 2020, and 2021. The survey was developed and disseminated in collaboration with the Business Institute and its partners. The goal of the RFI is to measure the extent to which CBOs are contracting with health care entities individually and as part of networks, and to better understand the services, target populations, payment models, and challenges related to these contracts. This report presents key findings from the 2021 RFI survey and describes some contracting patterns and trends.

KEY FINDINGS

Since the inception of the Business Institute, the proportion of CBOs contracting with health care has increased significantly, from 38% in 2017 to 44% in 2021. Among the CBOs who reported contracting with health care on the 2021 RFI, more than two-thirds who used Business Institute resources said those resources increased their knowledge of contracting, and more than one-third reported that the Business Institute helped them with each of the following components of contracting: beginning conversations with health care entities about potential contracts, entering into a contract, understanding alternative payment models, and strengthening an existing network.

Trends that emerged from the analysis of four waves of the RFI survey suggest some maturation of the CBO-health care contracting market. Indicators of these strengthened alliances include:

- The rise of CBO networks: The percentage of contracting CBOs who are entering those contracts as part of a network doubled between 2017 and 2021, from 20% to 40%.
- Strengthened revenue streams: Most contracting CBOs (80%) are now receiving payment for ALL of their contracts; the revenue situation was much more variable in previous years. In addition, the proportion of CBOs generating positive net revenue from at least one contract increased from 39% in 2020 to 47% in 2021.
- Improved partner perceptions: Perceptions of health care partners about CBOs had been noted as one of the top five challenges to contracting in the 2018 survey. It was not among the top challenges in 2021.
- Increased number of clients served under contract: The number of clients served by CBOs through their contracts with health care has increased by more than 100,000 in three years, from 249,095 in 2018 to 350,594 in 2021. The average number of clients per-CBO served under health care contracts doubled in that same time period, from an average of 896 in 2018 to 1,934 in 2021.
- Growth in Medicare Advantage plans as a health care partner: CBOs increased their involvement with Medicare Advantage. The percent listing Medicare Advantage plans as a contracting partner doubled between 2018 and 2020, from 10% to 20%, and held relatively steady during the ongoing pandemic.
- Increased use of value-based payment models for contracting: While fee-for-service is still the most common financing model, capitation and some value-based payment options became notably more common in 2021.

This report provides additional findings from the 2021 RFI survey about the current characteristics of CBO contracts with health care partners and illustrates the ways in which those arrangements are expanding services, reaching high-risk clients, focusing on SDOH, and tailored to the core strengths of the CBO and the priorities of the health care partner.

METHODS & RESPONSE RATES

The RFI 4 survey was launched in June 2021 and remained in the field for nine weeks, closing in August 2021. The online survey was disseminated by email to the population of 617 AAAs and 433 CILs; the response rates for these two groups were 54% and 30% respectively, as noted in Table 1. These response rates are notably higher than those for the 2020 RFI (30% and 24%, respectively), which was launched in March of 2020, just as the COVID-19 pandemic was taking hold. Other CBOs who had responded to previous RFI surveys also received email invitations to participate in RFI 4. In addition, Business Institute partners including ACL sent emails to their mailing lists to reach other CBO types. A total of 110 "other" aging and disability CBOs solicited through these channels participated in the survey. The most common non-AAA, non-CIL CBO respondents were support service providers, government agencies, and other non-profits. The response rate for this group cannot be calculated since there is no way to know the total number of organizations who received the request for participation through these networked channels.

Figure 1. Response by Organization Type

	RFI 1 2017	RFI 2 2018	RFI 3 2020	RFI 4 2021	
	n (resp rate)	n (resp rate)	n (resp rate)	**n (resp rate)**	**% of respondent pool**
Area Agency on Aging (AAA)	351 (56%)	409 (66%)	184 (30%)	**332 (54%)**	**58%**
Center for Independent Living (CIL)	119 (38%)	174 (28%)	95 (24%)	**130 (30%)**	**23%**
Other CBOs*	106	143	166	**110**	**19%**
Total	576	726	455	**572**	**100%**

** CBOs cover a broad range of organization types across the nation for which the true denominator is unknown, unlike AAAs or CILs.*

SURVEY RESULTS

CONTRACTING STATUS

Respondents were asked if they currently participate in contracts with health care entities. On the following page is the exact wording of the question from the survey.

Contract Definition and Question from RFI 4 (2021):

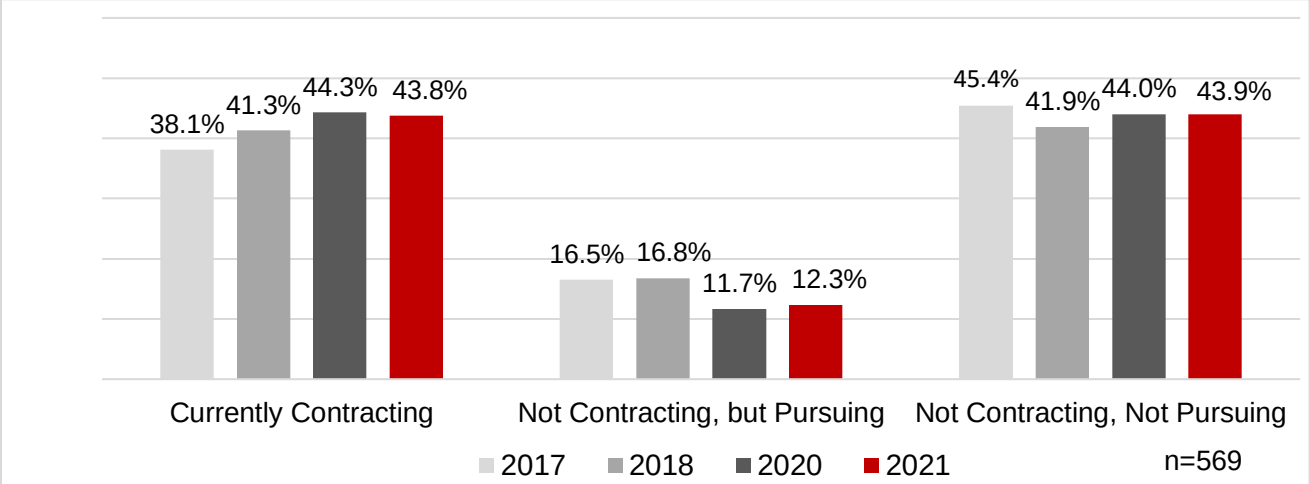
A contract is defined as a legally binding or otherwise valid agreement between two or more entities with the intent to exchange payment for services or programs. For the purposes of this RFI, we are interested in contracts where your CBO receives payment from the health care entity.

Does your organization currently participate in a contract to provide services or programs with or on behalf of a health care entity?

YES,	**NO,**	**NO,**
we **currently participate in contracts** with health care entities	**but** we are in the process of **pursuing a contract** with a health care entity	and we are **not pursuing contracts** with health care entities

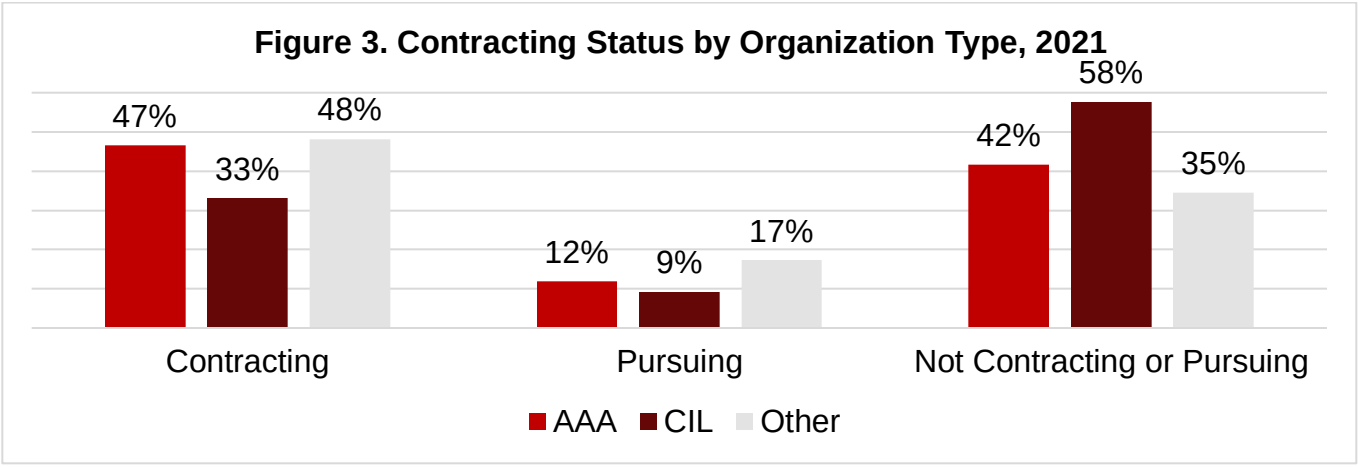
Figure 2 shows the percentages of CBOs with one or more contracts with health care partners since 2017. The percent of CBOs who are contracting has increased significantly since 2017 and has remained steady during the COVID-19 pandemic. This steady state is noteworthy given that nearly half of the CBOs who said they were pursuing contracts reported their efforts had to stop because their priorities shifted due to COVID-19; 44% of this same "pursuing contracts" group said their potential health care partners had to put the contract on hold because of the pressures and priorities created by the pandemic. Figure 3 shows the variation in level of contracting across the three organization types in the 2020 survey. AAAs and "other" CBOs had comparable levels of contracting that were about 15 percentage points above the level of contracting by CILs.

Figure 2. CBO Contracting Status, by Year



Depending on the response to the question about contracting, participants were routed to different survey questions appropriate to their situation**.** The following sections describing the nature and scope of contracts is based on the 249 respondents who said they have at least one contract in place. The average number of contracts held by these CBOs is 4, with a range from 1 to 50. For the vast majority (90%) of contracting CBOs, at least one of their current contracts has been renewed by a health care partner.

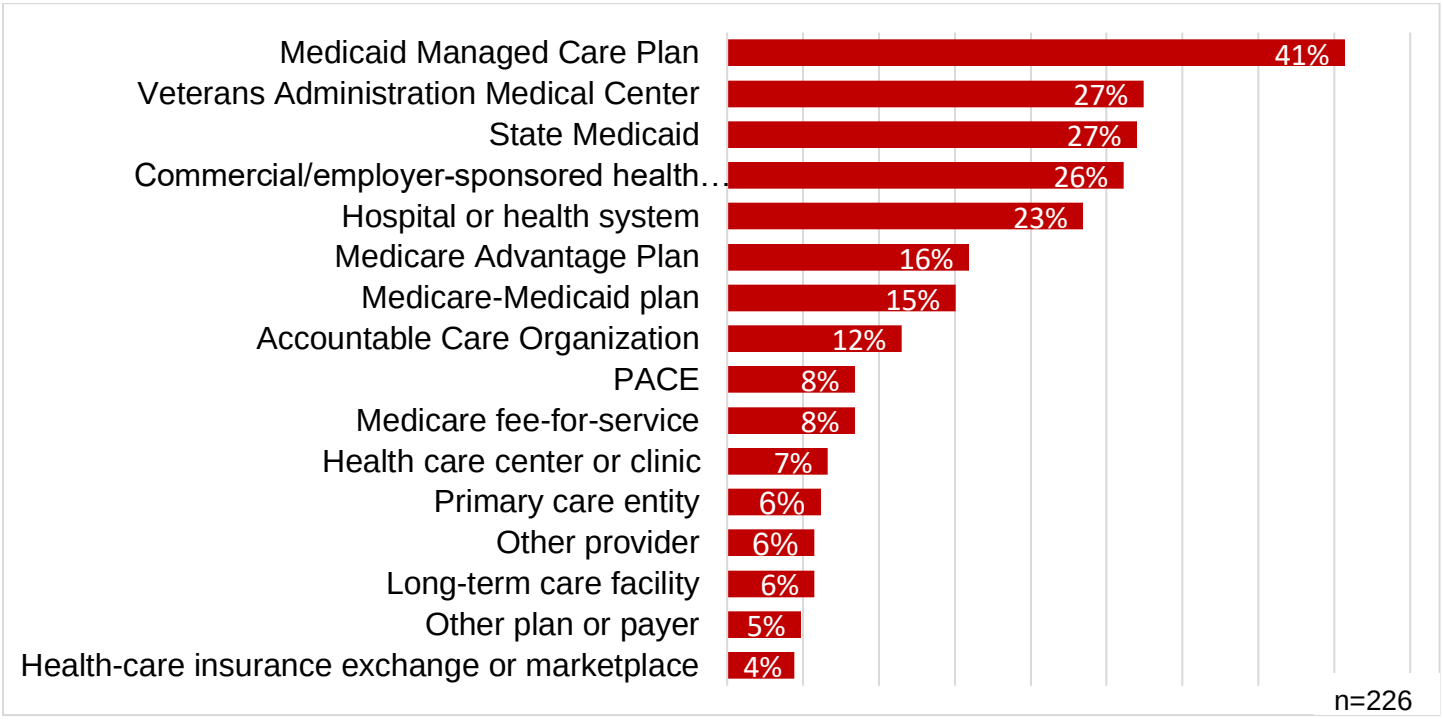
Figure 3. Contracting Status by Organization Type, 2021



CONTRACT PARTNERS, TARGET POPULATIONS, AND SERVICES PROVIDED

Medicaid Managed Care plans are the most common health care partners for CBOs with contracts, as shown in Figure 4. Rounding out the top five health care contracting partners are Veteran's Administration Medical Centers, state Medicaid that is not a pass-through for managed care, commercial/employer-sponsored insurance plans, and hospital/health systems.

Figure 4. Health Care Contract Partners



Who is being served through these contracts?

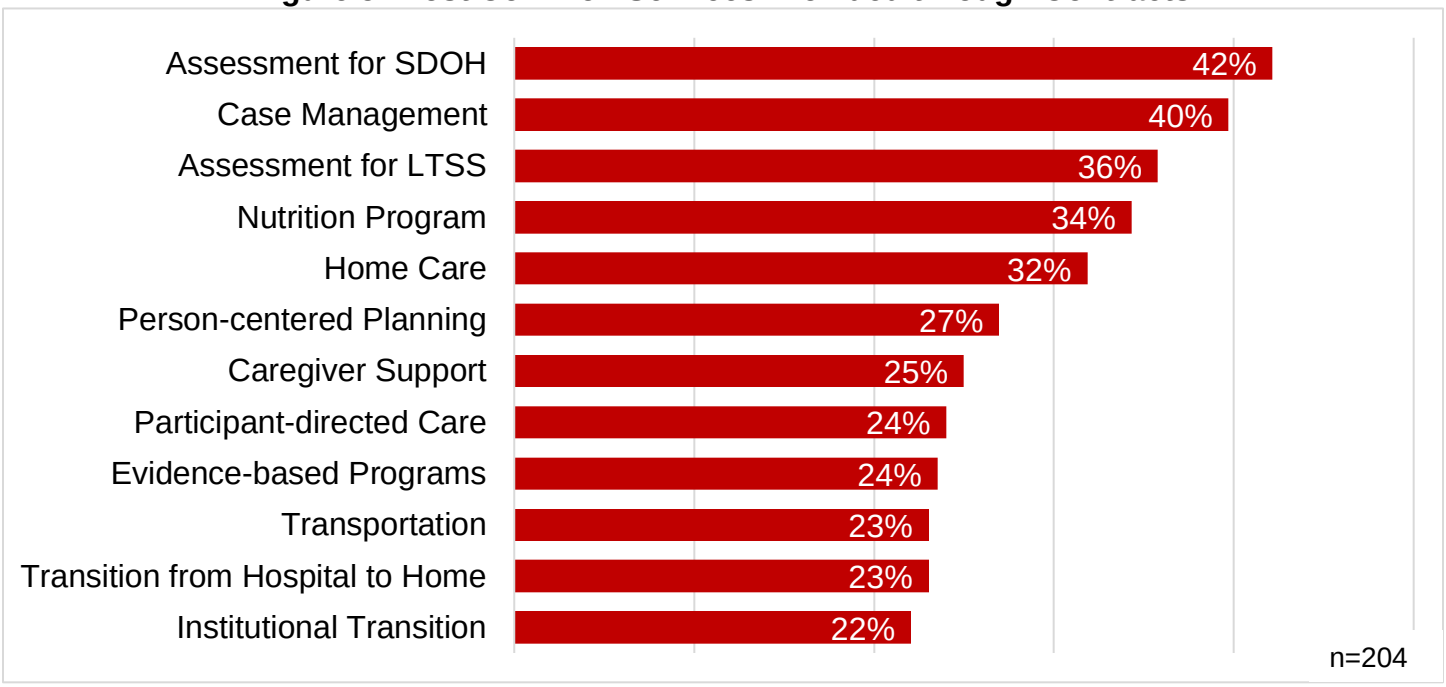
CBOs and CBO networks reported serving an average of 1,934 individuals over the past year through their contracts with health care partners, with a median of 210, and range from 0 (for CBOs with a contract in place but not yet serving clients) up to 120,000.

Through their contracts with health care, most CBOs serve older adults (72%) and/or individuals of any age with a disability or impairment (60%). In addition, they also serve individuals of any age with a chronic illness (43%); veterans (31%); adults (age 18 to 65) without a disability, impairment, or chronic illness (26%); and caregivers (21%) through their contracts.The majority (85%) of CBOs target high-risk or high-need groups through their contracts, including individuals at risk of nursing home placement (48%); individuals at high risk for emergency department use, hospitalizations, and/or hospital readmission (46%); individuals with a specific chronic illness diagnosis (other than dementia) (35%); individuals who are dually eligible for Medicare and Medicaid (31%); and individuals living with dementia (27%).

What services are provided through these contracts?

The most common services that CBOs provide through contracts with health care entities reflect some of their core specialties such as assessment for social determinants of health (SDOH) needs (42%); case management/care or service coordination (40%); assessment for long-term services and supports (36%); nutrition programs (34%); and home care (32%).

Figure 5. Most Common Services Provided through Contracts



While the most common services provided under contract align directly with the expertise of CBOs, it is interesting to note that the top services provided vary somewhat by health care partner. For example, the top services delivered under contract with a hospital or health care system were different from those delivered under contract with duals (Medicare/Medicaid) plans. Assessment and

nutrition services were most common for the duals-plan contracts, while care transitions and evidence-based health promotion programs were most common in contracts with health care delivery partners (hospitals and health systems). This difference illustrates both the range of services provided by CBOs under contracts, and their ability to meet the priorities of different health care partners.

PAYMENT MODELS AND REVENUE

Over three quarters of contracting CBOs (78%) reported that they had one or more contracts based on fee-for-service (FFS) such as FFS tiered rate, per service unit, or per service unit plus administration fee. Other payment models such as per member/per month and pay for performance/performance-based contracts were less common but had grown noticeably between 2020 and 2021. For example, in 2020, only 7% reported a capitation model for any of their contracts; in 2021, that percentage had grown to 30%. Nearly half (47%) of CBOs reported that they are generating positive net revenue for at least one of their contracts; 35% reported a budget neutral status and 30% reported they were running a deficit for at least one contract. The proportion of CBOs generating positive net revenue increased from 39% to 47% between 2020 and 2021. Another significant marker of the maturing of contracting relationships is that 80% of contracting CBOs were receiving payment for all of their contracts, a notable increase over previous years. Of those not receiving payment, the most common reasons reported were the CBO was not yet providing a service for which they could bill (47%), and there were issues with their agency's billing process (44%).

Contracting CBOs were asked to identify which measures were used in any contracts to determine their payment from health care entities. The most common measures include: numbers of clients served or service units provided (70%); accuracy/completeness of documentation, claims or other records (44%); submission of data/reporting (39%); and timeliness of output measures (33%).

DATA COLLECTION, ACCESS, AND UTILIZATION

Given the importance of data for CBOs' ability to assess the impact of their contract-based services, participants were asked to indicate whether they collected and/or had access to four kinds of data for at least one of their contracts: CBO organizational performance (such as return on investment), CBO program performance data (e.g. time from enrollment to service, care plan costs), client/patient quality of life (satisfaction, goals met), and client/patient health outcome data (e.g. functional changes, hospital readmissions). Access to program data was highest (54%), and access to client health data was the lowest (40%). Access to CBO organizational performance and client quality of life data were 43% and 44%, respectively.

To better understand the routes through which CBOs have access to these kinds of data, participants were asked whether they have access because they collect the data themselves, or whether they have access because the health care partner shares the data with them. Typically, CBOs have access because they collect the data themselves. For example, of those who have access to CBO performance data, 78% do so because they collect it themselves. CBOs are most dependent on health care partners for client health data; when they have access to this data, 40% of them do so because the health care entity shares it with them. The most common mechanisms to support data-sharing are business associate agreements with the health care partner (as specified under HIPAA),

entering data into multiple systems, and access to health care partner systems. The value and challenges of data access were highlighted in open-ended comments provided on the survey.

> *We fully depend on the health care entity to share relevant data with us on the impact our home delivered meals have had on the patient's health outcomes and readmission rates.*

> *Interoperability is a huge problem. Access to a hospital's system does not provide management reports and is insufficient to capture HCBS needs. [We have] weekly phone huddles and double entry is necessary. Health plans require use of a portal with no access to data; double entry is required.*

CONTRACTING EXPERIENCES: CHALLENGES AND POSITIVE CHANGES

CBOs with contracts were asked to report on the challenges they faced in setting up the contract, and those they continue to face as the contract is in place. Figure 6 compares the most common challenges out of a list of 28 in the two phases of the contracting relationship.

Figure 6. Top Seven Challenges for Contracting CBOs

	Was a challenge in establishing the contract (n=189)		Current challenge in the contracting relationship (n=188)	
1	Time it takes to establish a contract	43%	Negotiation of price and/or contract terms	32%
2	Negotiation of price and/or contract terms	34%	Referrals and volume	28%
3	Common understanding of proposed programs/services	26%	Staff turnover in the health care entity	26%
4	Timely payment for contracted services	23%	Timely payment for contracted services	25%
5	Staff turnover in the health-care entity	20%	Denial of claims	24%
6	Developing IT systems and training staff	19%	Integration of your organization's services into health care system workflow	21%
7	Competing priorities within the health-care community	18%	Willingness of health care partners to share data	20%

In the contract-establishment stage, typical challenges are time investments in setting up the contract, dealing with potential competing priorities for the health care partner, and coming to a shared understanding between the CBO and the health care partner. These challenges recede when the contract is in place. In the implementation phase, referrals, processing of claims, and access to data become more common challenges. An important change in top challenges has occurred over time; perceptions of health care partners about CBOs were a top-five challenge in 2018 but this concern

does not appear among even the top seven challenges in 2021 during the contract-establishment or the contract-implementation phases.

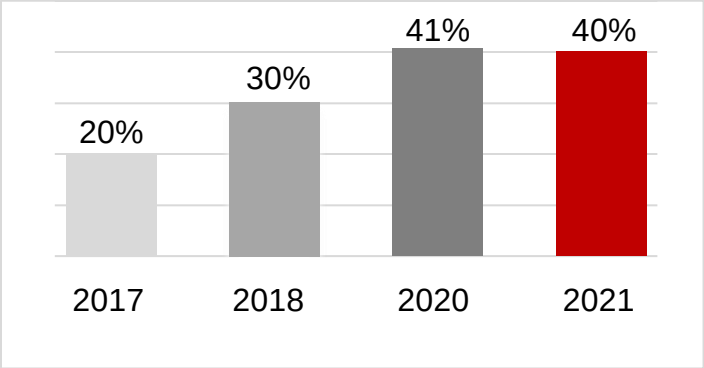
Survey participants were also asked about positive changes that occurred because of contracting. They identified the top five changes (from a list of 16) that were most significant to their organization. The most commonly reported changes were that they were able to: position their agency as a valuable health care partner (45%); increased number of people served (43%); obtain funding from new sources (38%); and enhance their organization's sustainability (38%).

CONTRACTING AS PART OF A NETWORK

Contracting through a network can enhance efficiency and effectiveness for health care partners and for CBOs. Networks—a coordinated group of CBOs that pursues a regional or statewide contract with a health care entity—allow organizations to achieve economies of scale in pricing, marketing, negotiating contracts, and centralizing some infrastructure.

Contracting as part of a network increased significantly over the past four years, as shown in Figure 6. About 40% of contracting CBOs indicated that they do so as part of a network. Since 2017, the proportion of CBOs that report contracting as part of a network has doubled (from 20% to over 40%).

Figure 7. Percentage of Contracting CBOs Who Do So as Part of a Network, 2017-2021



NOT CONTRACTING: ORGANIZATIONS PURSUING CONTRACTS

Just over 12% of respondents indicated that they were not contracting but were in the process of pursuing a contract; this is a slight increase from 2020. Organizations pursuing contracts were asked to identify where they would place their organization along a five-point continuum from exploring the idea of contracting with health care entities (1) to close to finalizing at least one contract (5). Over 80% of those pursuing contracts are in the stages of exploring the idea or engaging in discussions with potential health care partners. As shown in Figure 8, a small percentage (3%) were close to finalizing a contract. For those in the process of pursuing contracts, the most commonly noted challenges were integrating CBO services into health care system workflow, start-up funding to build infrastructure, funding for IT systems and staff training, negotiating price and/or contract terms, and competing priorities in the health care community.

Figure 8. Progress of Organizations Pursuing Contracts (n=69)

1	2	3	4	5
Taking the steps to explore the idea of contracting with health care entities		Engaging one or more health care entities in contract discussions		Very close to finalizing at least one contract
21.7%	**30.4%**	**36.2%**	**8.7%**	**2.9%**

Nearly 40% of those currently pursuing contracts indicated that their organization had actively pursued contracts in the past that were ultimately unsuccessful (contract was never agreed to and negotiations ceased). Those that were unsuccessful cited lack of Medicare and Medicaid provider status, lack of funding available from the potential partner, the pandemic, and stalled discussions as obstacles. Several also mentioned decisions by health care partners to keep services such as care management and some direct services in-house. Some of these barriers were described in open-ended responses on the survey.

> *We thought that the local hospitals would be interested in contracting with us for care transition work after the passage of the Affordable Care Act, but the hospitals ultimately explored starting their own ACOs or care transition departments rather than relying on CBOs.*

> *Medicaid Managed Care Organizations have chosen to provide services with MCO employees only except for home delivered meals. We do have contracts for waiver HDM's with two MCO's but payment rate is not equitable.*

NOT CONTRACTING: ORGANIZATIONS NOT PURSUING CONTRACTS

Consistent with years past, 44% of RFI respondents reported that they did not currently have a contract with a health care entity and were not pursuing contracts. Of these, 13% indicated that at one time they had a contract with a health care entity. The reasons why they no longer have a contract included not having enough referrals, the process was too cumbersome, and agreements were terminated.

When asked if they were interested in developing a contract with a health care entity, 41% indicated they were interested but needed more information or guidance before pursuing a contract. A small proportion of the not-contracting and non-pursuing CBOs (just over 6%) indicated that they have actively pursued contracts but have not been successful. The most common challenges faced by these organizations include startup funding to build infrastructure, need for a common understanding

of the proposed programs and services, competition for contracts from other organization or networks, attitude of health care professionals towards their organization, and the integration of their organizations services into a health care system workflow.

Respondents who were not currently pursuing contracts were asked about their organization's position on contracting with health care entities. In open-ended responses, some CBOs expressed a desire to learn more and optimism about future possibilities, while others described challenges and limitations they face within their own organization or with the health care entities in their area

- *It's a good idea! Especially in making healthcare facilities more accessible to people with disabilities and providing disability sensitivity training. We can help each other and healthcare entities should utilize Centers as a resource for individuals who just acquired a disability with nowhere to turn. The financial part has to be worthwhile to Centers to train and commit staff to a project that would include contracting with health-care entities.*

- *Our organization tried to contract for our evidence- based Matter of Balance program but the health care community was not interested in pay for these classes. They did not feel the outcome from these classes met their criteria for billing. We do partner on referrals being made by physicians, assisted living centers and other community based organizations.*

- *I know very little about what it might look like to contract with a health-care entity. I would be willing to learn more. If it means providing another level of service to people with disabilities, we would certainly want to pursue any opportunities*

SUMMARY

The proportion of CBOs with health care contracts has increased significantly since the first RFI survey in 2017 (one year after the start of the Business Institute). Important markers of the increasing maturity of these partnerships have emerged during the four waves of the RFI survey. Contracting as part of a network of CBOs is becoming more common and more CBOs are taking advantage of new opportunities, such as contracting with Medicare Advantage plans. Services provided under contract reflect the core strengths of CBOs and are tailored to the priorities of different health care partners. The agility and responsiveness of CBOs is also demonstrated by the fact that 90% modified the services provided in their contracts to meet pandemic-related needs. Fee-for-service remains the most common way that CBOs receive payment for their contracts with health care, but notably higher proportions reported capitation-based and value-based models in 2021 than in the previous year. Data collection and sharing remains a challenge for building evidence about the effectiveness of such arrangements; CBOs are more likely to collect and have access to data about program or performance data compared with client data. Challenges related to contracting revealed two important trends: first, the nature of challenges varies depending on the stage of the contract (formation v. implementation); second, the nature of challenges has changed over time, with perceived attitudes of health care partners toward CBOs disappearing from the list of top concerns. Finally, organizations with contracts noted specific ways that the Business Institute resources helped

them with the contracting process; those without contracts expressed a need for technical assistance and support. Taken together, these findings reinforce the value of the resources provided by the Aging and Disability Business Institute.

ACKNOWLEDGEMENTS

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The USAging Aging and Disability Business Institute team includes Sandy Markwood, Marisa Scala-Foley, Elizabeth Blair, Traci Wilson, Maya Op de Beke, Kathie Garbie, and Meredith Bratton. For additional information about the Business Institute and related resources, please visit: www.aginganddisabilitybusinessinstitute.org.

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ENDNOTES

Brewster, A., Kunkel, S., Straker, J. & Curry, L. 2018. Cross-sectoral partnerships by Area Agencies on Aging: Association with health care use and spending. *Health Affairs* 37 (1). https://doi.org/10.1377/hlthaff.2017.1346
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