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# Community-Based Organizations and Health Care Contracting: Building & Strengthening Partnerships

SUZANNE R. KUNKEL, ABBE E. LACKMEYER, JANE K. STRAKER, TRACI L. WILSON

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## Background

Social determinants of health – including housing, nutrition, social and community engagement, and access to health care, services, and supports – impact individual health outcomes, population health, and health care spending. Community-based organizations (CBOs) such as Area Agencies on Aging (AAAs) and Centers for Independent Living (CILs) are well-positioned within their communities to improve social determinants of health. Therefore, partnerships between CBOs and health care entities are potentially an important factor in improving health outcomes while reducing health care expenditures.

The Aging and Disability Business Institute (Business Institute) was established in 2016 to provide tools and resources to support the capacity of CBOs to enter into successful contracts with health care entities. For more information on the Business Institute, see the back page of this report. Since the establishment of the Business Institute, two "Request for Information" (RFI) surveys have been administered by Scripps Gerontology Center in partnership with the National Association of Area Agencies on Aging (n4a). The first RFI was launched in July 2017 to understand the landscape of contracting between CBOs and health care entities. Findings from the first RFI can be found in the Research Brief *Community-Based Organizations and Health Care Contracting.*[1]

To build upon these findings, the second RFI was launched in May 2018. The second RFI included some of the same key questions as the first about the nature and number of contracts with health care partners in addition to new questions about the logistics of contracting, perceived organizational changes, and challenges of contracting. The survey was disseminated via email directly to 617 AAAs and 623 CILs; the response rates for these two networks were 66.3% and 27.9%, respectively. The survey was also disseminated to other CBOs through announcements from a network of key national agencies including non-profits and government agencies involved in aging and disability services, policy, and advocacy. The survey was in the field for nine weeks between May and July 2018. A total of 726 respondents completed the survey.

## Key Findings

The proportion of CBOs contracting with health care entities

**increased**

from 2017 to 2018

Nearly

**250,000 individuals**

were served through contracts with health care entities last year

The most common partnership continues to be with

**Medicaid MCOs**

(managed care organizations)

## Results

Area Agencies on Aging were 56.3% of the respondents. An additional 24.0% of respondents were CILs and 19.7% identified themselves as an 'other' CBO. The most common 'other' CBOs were supportive service providers; other non-profit organizations; and government departments of health, aging, disability, mental/behavioral health, and human services.

Respondents were asked to indicate if they currently have a contract to provide services or programs with or on behalf of a health care entity. A contract was defined in the survey as a "legally binding or valid agreement between two or more entities with the intent to exchange payment for services or programs." As shown in Figure 1, the proportion in 2018 that currently have one or more contracts with a health care entity is nearly identical to the proportion who are not currently pursuing contracts (41.3% and 41.9%, respectively). The remaining organizations (16.8%) indicated they currently do not have a contract but are in the process of pursuing one.

Comparing contract status by year, these findings represent an 8% increase in the proportion of organizations that have a contract, and a 2% increase of those in the process of pursuing a contract. There was an 8% decrease in the proportion of organizations that do not have a contract and are not pursuing contracts. These changes (depicted in Figure 1) show positive movement in a relatively short period of time - less than one year - in the involvement of CBOs with health care entities. Another perspective on the progress among CBOs comes from the results for agencies that participated in both RFIs: nearly one-third (31.0%) of the agencies that were pursuing contracts in 2017 had at least one contract in place in 2018.

**Figure 1. Overall Contracting Status, by Year**

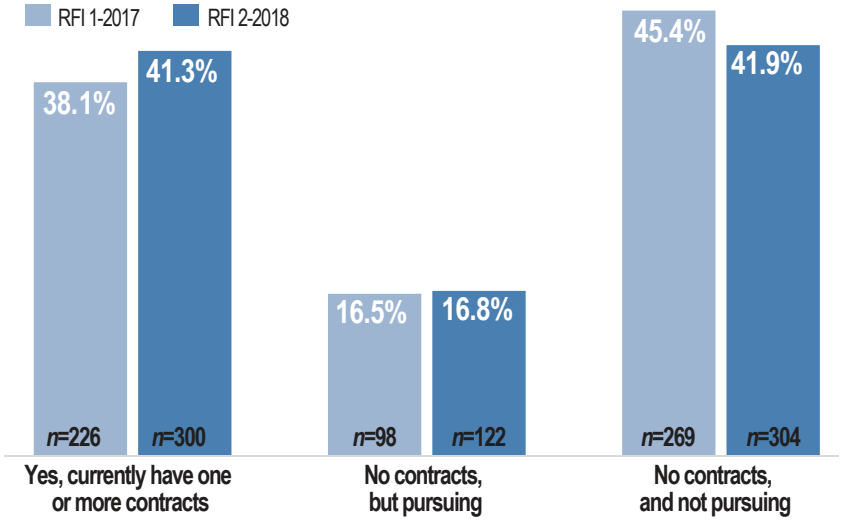
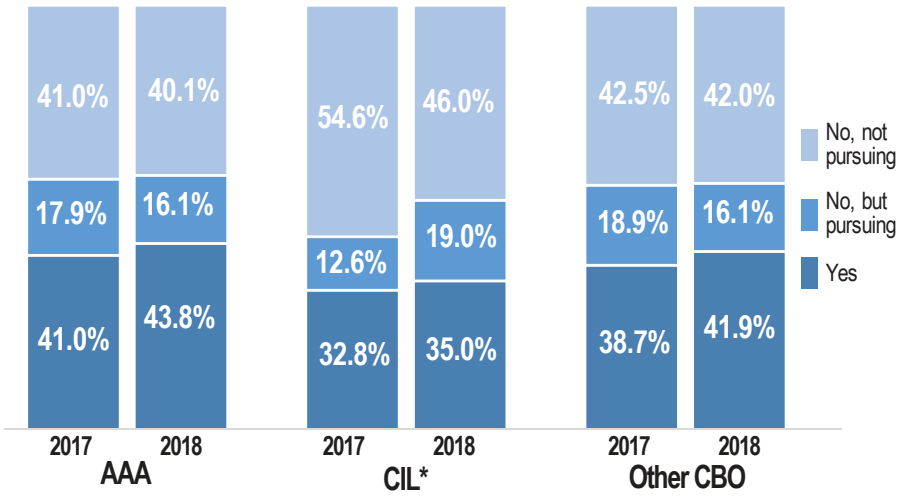



**Figure 2. Contracting Status: Comparing RFI 1 to RFI 2 for Each Agency Type**




*Please note that the overall number of CILs reached directly doubled from 2017 due to database access

Each agency type showed the same positive trend between 2017 and 2018. As shown in Figure 2, AAAs, CILs and Other CBOs all experienced a slight increase in the proportion who are contracting with a health care entity and a decrease in the proportion that do not have a contract and are not pursuing one.

## Organizations Contracting with Health Care Entities

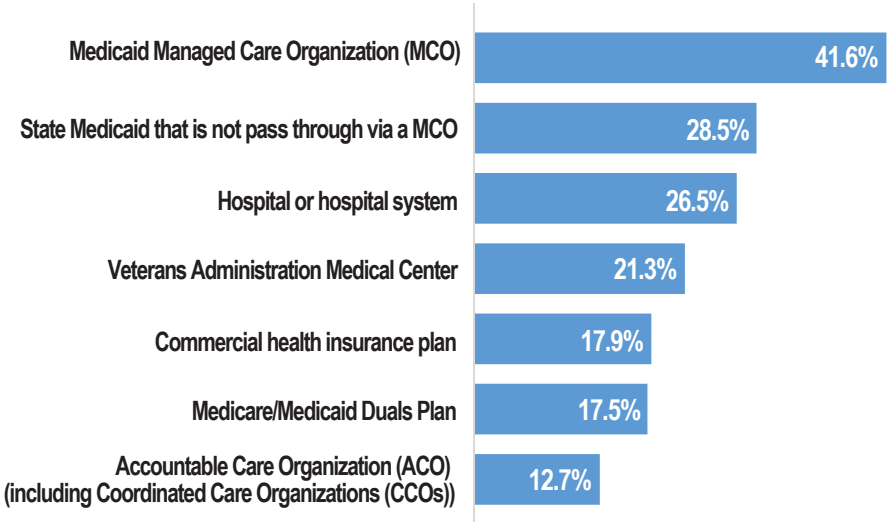
Among the 300 organizations that indicated that they currently have one or more contracts with health care entities, the number of contracts ranged from 1 to 100, with a median of 3. Nearly eighty percent (77.9%) of organizations signed their first contract with a health care entity within the last 10 years; the median is five years.

To create synergy and be more competitive for contracts, many organizations are entering into contracts with health care entities as part of a network. Being part of a network allows organizations to achieve economies of scale in pricing, marketing, and negotiating contracts. In addition, it appeals to health care payers seeking regional or statewide reach. For the purposes of this survey, a network was defined as a "coordinated group of community-based organizations that pursues a regional or statewide contract with a health care entity." In 2018, nearly one-third (30.2%) of organizations with contracts entered into a contract as part of a network. This is an increase of 10.5 percentage points over the proportion of organizations that entered contracts as part of a network in 2017.

### *Who are CBOs contracting with?*

The most common health care partners for the 300 organizations with contracts are Medicaid managed care organizations (MCOs) (41.6%). In addition, State Medicaid (that is not a pass through via an MCO), hospital or hospital systems, and Veterans Administration are other commonly identified partners, as shown in Figure 3.

**Figure 3. Most Common Health Care Partners**




### *Who is being served through these contracts?*

Organizations were asked to identify all of the target populations they serve through their contracts with health care entities. The majority of organizations serve older adults (age 65+) (78.0%) and/or individuals with a disability, impairment, or chronic illness (63.8%). In addition, 34.8% serve Veterans; 29.6% serve adults (age 18-65) without a disability, impairment, or chronic illness; 23.0% serve caregivers of any age; and 12.9% serve children (up to age 18).

Many contracts target high-risk or high-need groups, such as individuals with a specific diagnosis or financial needs. Most organizations (85.5%) said that their contracts do target high-risk and/or high-need groups. The groups most typically targeted are those at risk for nursing home placement (58.0%), and individuals at high risk for emergency room use, hospitalization, and hospital readmission (54.8%). In addition, 38.9% of the contracting organizations target individuals who are dually eligible for Medicare and Medicaid, 29.0% serve individuals with a specific diagnosis, and 23.0% serve individuals who have an intellectual and/or developmental disability and/or traumatic brain injury.

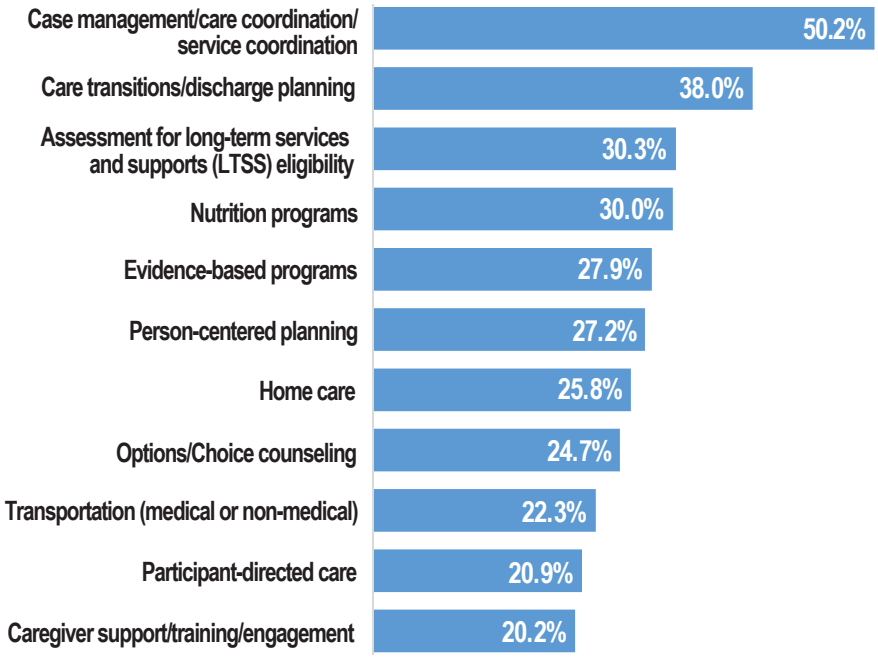
### *How many people have been served by these contacts?*

Within the past year, 278 contracting organizations reported serving an average of 896 individuals each through all their contracts. Based upon self-reported estimates from respondents, 249,095 individuals were served through contracts over the past year.

### *What services and programs are being provided through these contracts?*

Half of the contracting organizations offer case management/care coordination/service coordination through their health care contracts. Figure 4 shows that the other commonly provided services and programs include care transitions and discharge planning, assessment for long-term services and supports (LTSS) eligibility (including level of care/ functional assessment), nutrition programming (e.g., counseling, meal provision), and evidence-based programs (e.g., fall prevention programs, Chronic Disease Self-Management, medication reconciliation programs).

**Figure 4. Most Common Services & Programs Provided Through Contracting**




### *How are CBOs receiving payment?*

Most (82.4%) contracting organizations currently receive payment for all of their contracts with health care entities. For the 17.6% that do not receive payment for all of their contracts, the most cited reasons include not yet providing a service for which they can bill, and issues with the payer's internal process.

The most common type of payment model is fee-for-service (FFS) (63.1%). This includes FFS tiered rate, per service unit, and per service unit plus administration fee. The FFS payment model is followed by per member per month (PMPM) and other capitation (e.g., partial capitation, full-risk capitation) (29.8%) and case rate (e.g., per participant, per discharge) (27.7%). Respondents were asked how many of their contracts have a pay-for-performance criteria; only 21.3% of contracting organizations indicated they had one or more contracts with pay-for-performance criteria.

### *What data is being collected and accessed by CBOs?*

Data collection and data sharing are often part of contractual arrangements between CBOs and their health care partners, yet little is known about how common this is and what types of data are being shared. Respondents were asked to report what types of data their organization collects and what types of data they have access to as a result of the contract. Table 1 shows the percentage of organizations that collect and/or have access to particular types of data.

**Table 1. CBO Collection of and Access to Data**

| | Data Collection | | | Data Access | | |
|---|---|---|---|---|---|---|
| | Collects for any contract | Does not collect | Don't know | Access for any contract | Does not have access | Don't know |
| CBO organizational performance data | 48.2% | 33.8% | 18.0% | 47.5% | 30.9% | 21.6% |
| CBO program or service performance data | 62.9% | 22.4% | 14.8% | 58.7% | 23.9% | 17.4% |
| Client/patient health outcome data | 51.4% | 35.3% | 13.3% | 50.8% | 32.2% | 17.0% |
| Client/patient quality of life outcome data | 47.1% | 34.1% | 18.8% | 43.9% | 33.3% | 22.8% |

Examples of the above data types include: **CBO organizational performance data** (ROI, staff performance, organizational reach); **CBO program or service performance data** (time from enrollment to service, client uptake, source of referrals, cause of disenrollment, care plan costs); **Client/patient health outcome data** (functional changes, length of stay in program, diagnoses, hospital re/admissions); **Client/patient quality of life outcome data** (service satisfaction, individual goals, individual preferences). *N*= 278

About half of responding CBOs collect some form of data. Across all types of data, the proportion of respondents having access to data is smaller than the proportion reporting that they collect that type of data. Overall, client data is less often collected than CBO performance or program data, with client quality of life being least likely to be collected and shared. A large proportion of CBOs "don't know" if a particular type of data is collected and/or accessible to them.

When asked to provide open-ended comments about their data collection and sharing efforts, several CBOs highlighted the challenge and inefficiency of working across multiple platforms. Shared data platforms and integration into workflow provide opportunities to streamline work for CBOs and their partners.

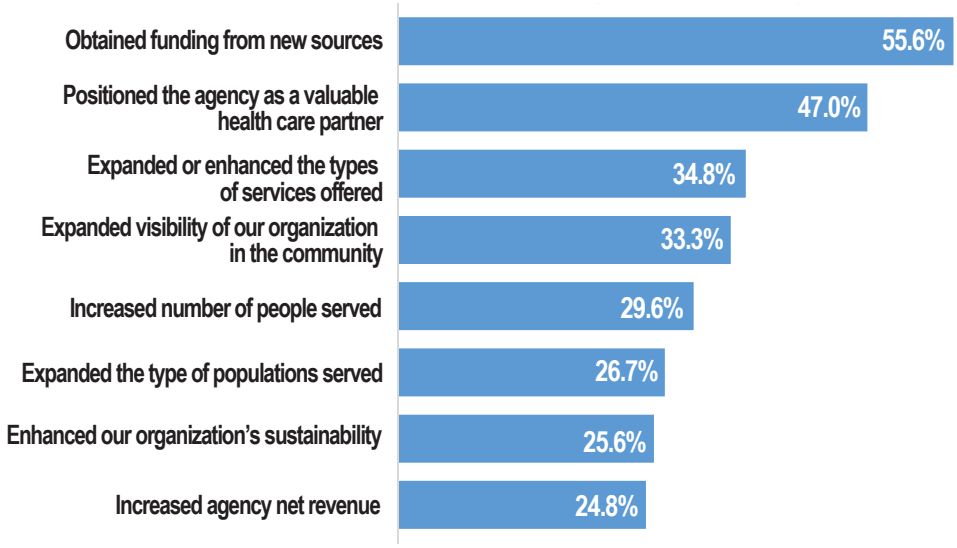
> *"Data collection is very difficult. Each of our MCO partners requires we document and track client activity in their respective platforms. There is not one universal system to capture all the data…"*

> *"The biggest issue we face is access to good, actionable data. We have very limited access to any information and most of that is not in actionable, reportable, manageable formats. It's nothing more than general information, most often on hitting timeframes. This is one of the most critical problems facing CBOs related to contracting with MCOs and health systems."*

## What Changes Have CBOs Experienced as a Result of Contracting?

The process of establishing and maintaining a contractual relationship often requires CBOs to make strategic changes within their organizations to ensure that their partnerships will be successful. As a result, CBOs involved in contracts report a number of changes that were significant to their organization. Respondents were asked to identify up to five of the most significant changes from a list of 16 positive or neutral changes which ranged from expanding the services they provide to cultural changes within their organization. The most common change was obtaining funding from new sources (55.6%) followed by positioning their agency as a valuable health care partner (47.0%). Interestingly, only one-quarter indicated that contracting had increased their net revenue. (Figure 5.)

**Figure 5. Most Common Changes Experienced by Contracting CBOs**



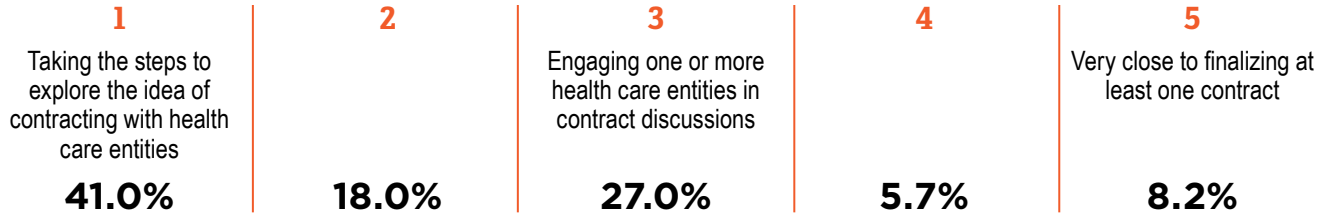

*"There was a local health system that had declined to participate with us and other local hospitals in the Community-based Care Transitions (CCTP) project. After the CCTP project ended, this health system has become our strongest ally and we continue to build our contract relationship. This has been due to several factors: our performance outcomes from the CCTP project; both sides continuing to foster a non-financial relationship; identification of a key champion within the health system and further development of additional champions; our ability to provide a network of other providers outside of our geographic service area that will provide the same service to their other hospitals."*

*"Our biggest success was being able to secure approval for use of funds akin to 'start-up' dollars from our governing board. Without the ability to spend front end monies for the hiring, training and technologies necessary for the work we are doing with clients, we would not be the success we are today. Those monies are now able to be paid back to the fund sources where they originated... [thanks to] the great work that is accomplished every day by our professional care coordinators. [We] help clients achieve better health outcomes and experiences, reducing costs to the Medicare and Medicaid systems."*

## Organizations Pursuing Contracts

Almost 17% of respondents indicated that they do not currently have a contract with a health care entity but are in the process of pursuing a contract. These respondents were then asked to identify where they would place their organization along a continuum of progress towards contracting. The largest proportion of those pursuing contracts (41.0%) are at the early stages of exploring the idea of contracting; 27.0% are engaging one or more health care entities in contract discussions. Less than 10% said they were very close to finalizing a contract. (Figure 6.)

**Figure 6. Progress of Organizations Pursuing Contracts**




## Organizations With No Contracts & Not Pursuing Contracts

Nearly 42% of respondents indicated that they do not currently have a contract with a health care entity and are not in the process of pursuing one. Of these agencies, 39.1% are interested in developing a contract with a health care entity but need more information or guidance before pursuing. Another 34.8% of these agencies have not thought about pursuing a contract or have no plans to do so at this time. The smallest proportion (9.3%) said that they have actively pursued contracts but have not been successful. (Table 2.)

**Table 2. Interest in Contracting Among Organizations without Contracts**

| | |
|---|---|
| Yes, but not at this time | 16.9% |
| Yes, but we need more information or guidance before pursuing | 39.1% |
| Yes, and we have actively pursued contacts but have not been successful | 9.3% |
| No, this is not something we plan to pursue | 16.9% |
| No, we have not thought about pursuing a contract with a health care entity | 17.9% |

Organizations that are not currently contracting stated in open-ended responses that they are struggling with how to begin the contracting process, and that they need additional training.

> *"It seems too big to bite off. I don't know how to even begin. It doesn't feel like we have the capacity, time, resources, or structure to pull it off."*

> *"[AAAs] need more training to move into this direction. We need training on how we package our program to entice health care entities to contract with us."*

## Contracting Challenges

Whether an organization has contracts, is pursuing contracts or may have been unsuccessful in trying to establish a contract, there are challenges to their contracting efforts. Respondents were asked to identify up to five of their biggest challenges from a list of 24 options ranging from internal culture challenges to system or IT issues. For those who have one or more contracts, the most commonly reported challenge was the time it took to establish a contract (33.9%). For organizations that are pursuing a contract, having a common understanding of proposed programs/services is the top obstacle (39.3%). For organizations that are not involved in contracting, but had once tried and were unsuccessful, the most common challenge was the attitudes of health care professionals towards their organization (42.9%). Interestingly, the following three challenges were identified by each group as one of their top challenges: common understanding of proposed programs/services, integration of the organizations' services into health care system workflow, and attitudes of health care professionals towards the organization. The blue font in Table 3 highlights the challenges that were shared by all three groups.

**Table 3. Top 5 Challenges by Contracting Status**

| | Organizations with one or more contracts (*n*=274) | | Organizations with no contracts but pursuing (*n*=122) | | Organizations with no contracts and not pursuing (but tried and were unsuccessful) (*n*=28) | |
|---|---|---|---|---|---|---|
| 1 | Time it takes to establish a contract | 33.9% | **Common understanding of proposed programs/ services** | 39.3% | **Attitudes of health care professionals toward your organization** | 42.9% |
| 2 | **Common understanding of proposed programs/ services** | 33.6% | **Integration of your organization's services into health care system workflow** | 38.5% | Competing priorities within the health care community | 35.7% |
| 3 | Referrals and volume | 27.4% | **Attitudes of health care professionals toward your organization** | 34.4% | Leadership changes within health care entities | 32.1% |
| 4 | **Attitudes of health care professionals toward your organization** | 25.9% | Willingness of your organization to take financial risk | 27.9% | **Integration of your organization's services into health care system workflow** | 32.1% |
| 5 | **Integration of your organization's services into health care system workflow** | 24.8% | Time it takes to establish a contract | 27.0% | **Common understanding of proposed programs/ services** | 28.6% |

[1]Kunkel, S. R., Straker, J. K., Kelly, E. M., & Lackmeyer, A. E. (2017). Community-Based Organizations and Health Care Contracting. Scripps Gerontology Center, Oxford, Ohio. Available at: http://bit.ly/2iW6mQL

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The n4a Aging and Disability Business Institute Team includes: Sandy Markwood, Marisa Scala-Foley, Mary Kaschak, Elizabeth Blair, and Maya Op de Beke. For additional information about the Business Institute and related resources, please visit: aginganddisabilitybusinessinstitute.org.

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MIAMI UNIVERSITY
SCRIPPS GERONTOLOGY CENTER
*An Ohio Center of Excellence*

100 Bishop Circle, Upham Hall 396
Oxford, OH 45056

ScrippsAging.org | Scripps@MiamiOH edu
513.529.2914 | Fax 513.529.1476