Strengthening Ties: Contracting Between Community-Based Organizations and Health Care Entities

Scripps Gerontology Center
Miami University

Suzanne R. Kunkel, Traci L. Wilson,
Abbe E. Lackmeyer & Jane K. Straker

December 2020

Background

Effectively meeting social needs such as adequate nutrition, safe housing, and access to transportation can influence individual and community health. Community-based organizations (CBOs) such as Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), and other providers of supportive services are well-positioned to coordinate and deliver programs that address social needs within 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.

The Aging and Disability Business Institute (Business Institute), led by the National Association of Area Agencies on Aging (n4a), supports the business acumen of CBOs to enhance contracting with health care partners. With continued funding from The John A. Hartford Foundation, the Administration for Community Living (ACL), and The SCAN Foundation, the Business Institute is building on initial successes in increasing the extent of contracting relationships to address the changing integrated care environment. This phase of the project will increase knowledge and resources related to network-based contracting, payment models, new opportunities such as Medicare Advantage Special Supplemental Benefits for the Chronically Ill, and perspectives of health care partners.

Scripps Gerontology Center serves as the independent project evaluator for the Business Institute. A cornerstone of the evaluation is repeated national surveys about the extent and nature of CBO contracts with health care entities. This report summarizes findings from the third Request for Information (RFI) survey (previous RFIs were conducted in 2017 and 2018). The survey and this report were 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 a network, and to better understand the services, target populations, payment models, and challenges related to these contracts.

44%
of CBOs report one or more contracts with a health care entity

Since 2017, the proportion of contracting CBOs that contract as part of a network has *doubled*

43%
of contracting CBOs say it's positioned them as a valuable health care partner

METHODS & RESPONSE RATES

The survey was disseminated by email to the population of 617 AAAs and 404 CILs. Other CBOs who had responded to previous RFI surveys also received email invitations to participate. In addition, Business Institute partners, including ACL, sent emails to their mailing lists to reach other CBO types. The survey was launched March 3, 2020. At that time, the public was aware of COVID-19, but not the extent to which it was spreading throughout the U.S. During the second half of March, aging and disability CBOs had to quickly adjust their services in response to suspension of in-person activities, including the closure of congregate meal sites and senior centers, and concerns about the safety of in-home care and transportation. The immediate priority was how to ensure continuity of services for community-dwelling clients. The COVID-19 pandemic placed a significant burden on the agencies who were the target population for the RFI survey. Based on ongoing consultation with the Business Institute, the survey team did not undertake aggressive follow-up strategies to increase response rates; we also made sure that all communication acknowledged the challenging situation faced by CBOs. The combined Scripps-Business Institute team, with input from funders, decided to close the survey in mid-May.

A total of 445 organizations responded. Table 1 shows the number of respondents by organization type for each wave of the RFI. Within the section for each wave, the first column, *n (response rate)*, shows the number of respondents for a particular organization type, and the response rate for that group. For example, in the 2018 RFI, 66% of AAAs responded, while in 2020, 30% of AAAs completed the survey. The second column, *% of RFI respondents*, shows what proportion that organization type represents in the survey. In 2017, other CBOs made up 18% of survey respondents, while in 2020, they made up 37% of respondents. The most common other CBO types were supportive service providers, non-profit organizations, and government departments.

Table 1. RFI Response and Proportion by Organization Type and Wave

	RFI 1 (2017)		RFI 2 (2018)		RFI 3 (2020)	
	n (response rate)	% of RFI respondents	n (response rate)	% of RFI respondents	n (response rate)	% of RFI respondents
Area Agency on Aging (AAA)	351 (56.3%)	60.9%	409 (66.3%)	56.3%	184 (30.3%)	41.3%
Center for Independent Living (CIL)	119 (38.0%)	20.7%	174* (42.4%)	24.0%	95 (23.5%)	21.3%
Other CBOs	106 (na)**	18.4%	143 (na)	19.7%	166 (na)	37.3%
Total	576	100%	726	100%	455	100%

**The denominator for CILs increased between 2017 and 2018 as we received an expanded contact list which included independent CIL satellites.*

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

Response Rate Implications

In addition to the decreased number of respondents overall, the composition of respondents changed in 2020. In the first two waves, about 60% of respondents were AAAs, 20% CILs, and 20% other CBOs. In this wave, AAAs represent only 40% of the respondents, and "other CBOs" represent a larger proportion and number than in previous waves.

We conducted a non-response bias analysis on AAAs to determine if there were types of AAAs who were more or less likely to respond to the 2020 RFI. Based on the key indicators of contracting status, organizational structure, geographic area served, and agency budget, we did not find any patterned non-response in 2020 compared to previous waves.[1] This result increased confidence that while the number of AAA respondents was smaller than in the past, there is no particular type of AAA that is significantly underrepresented in the 2020 RFI data.

The change in composition of the respondent group for this RFI likely has some impact on trend data, because different organization types might be involved with different partners and services. To avoid misinterpreting trends over time, this report describes findings from the 2020 RFI only, except for trends in overall contracting and contracting as part of a network.

Results

Contracting Status

Respondents were asked if they currently participate in contracts with health care entities. They were then routed to different survey questions based on their response.

Contract Definition and Question from RFI 2020:

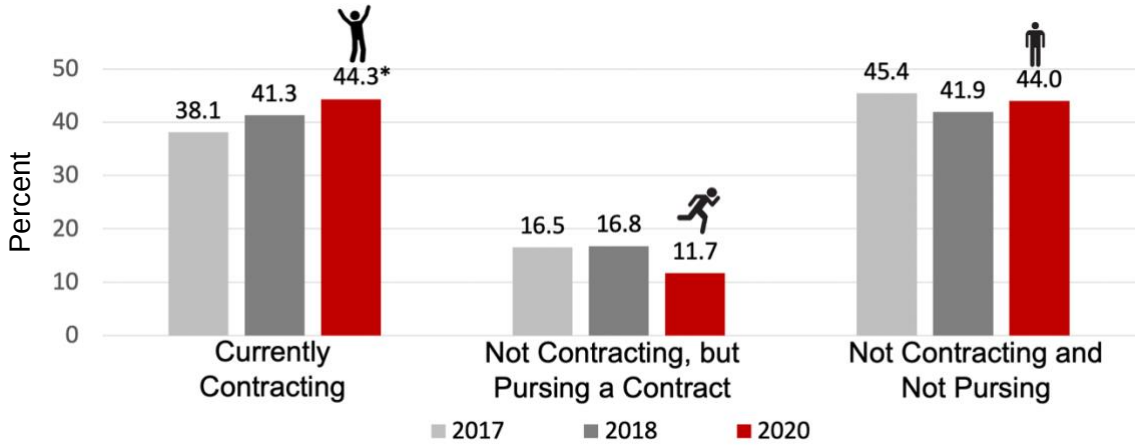
A contract is defined as a legally binding or otherwise valid agreement between two or more entities with the intent to exchange payment for services or programs. For the purposes of this RFI, we are interested in contracts where your CBO receives payment from the health care entity.

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 1 shows that 44% of CBOs indicated that they currently participate in one or more contracts with health care entities. This represents a statistically significant increase from 2017. Forty-four percent reported they were not currently contracting nor pursuing a contract, and about 12% reported they were not contracting, but were pursuing a contract with a health care entity.

Figure 1. Status of CBOs Contracting with Health Care Entities, 2017-2020



**Statistically significant increase from 2017 to 2020 in proportion of CBOs reporting contracts.*

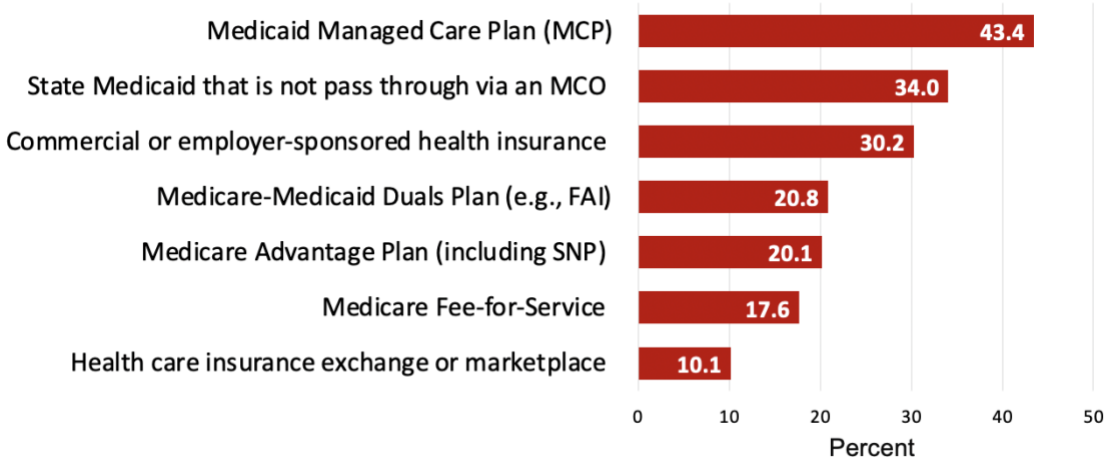
CONTRACTUAL PARTNERS, TARGET POPULATIONS, AND SERVICES

For the 181 CBOs who reported details about their contracts, the number of contracts they currently hold ranged from 1 to 100, with a median of 3 contracts. Over half of CBOs (52.2%) signed their first contract with a health care entity in 2014 or later. CBOs have held their longest-running active contract for a median of 5 years, with a range of 0 to 45 years.

Who are the payers and providers contracting with CBOs?

Figure 2 shows the proportion of CBOs contracting with various health care ***payer*** partners. The most common payer partner is Medicaid Managed Care Plans (MCP): 43% of contracting CBOs have a contract with a Medicaid MCP. State Medicaid that is not a pass through via a Managed Care Organization (MCO) (34%) and commercial or employer-sponsored health insurance plans (30%) are the next most common.

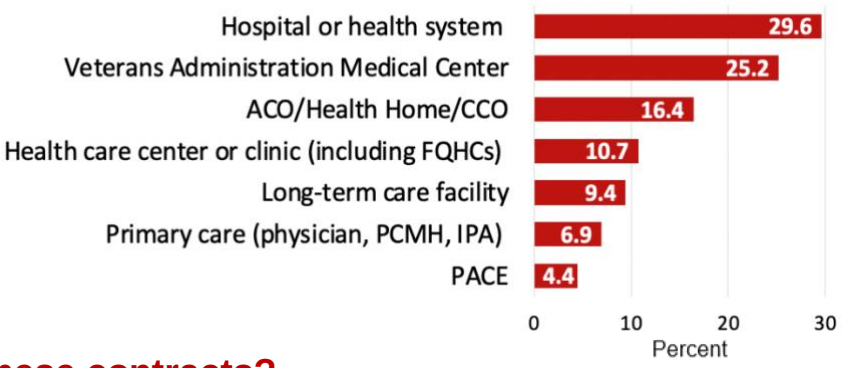
Figure 2. Health Care Contract Partners: Payers



Also noteworthy is that the proportion of CBOs contracting with Medicare Advantage plans doubled from about 10% in 2018 to 20% in 2020, a statistically significant increase. This same time period saw the expansion of supplemental benefits available under Medicare Advantage.

Figure 3 shows the most common health care ***provider*** contract partners, which are: hospitals/ health systems (30%), Veterans Administration Medical Center (25%), and Accountable Care Organizations (ACO)/Health Home/Coordinated Care Organizations (CCO) (16%).

Figure 3. Health Care Contract Partners: Providers



Who is being served through these contracts?

CBOs reported serving an average of 1,274 individuals over the past year through their contracts with health care partners, with a median of 250.

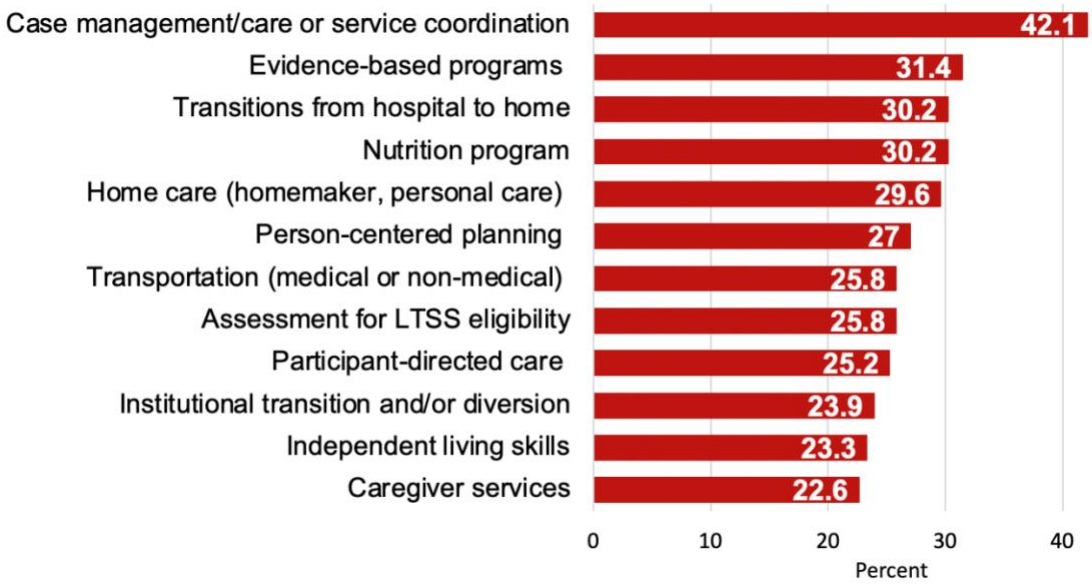
The majority of CBOs with health care contracts serve older adults (76.0%) and/or individuals of any age with a disability or impairment (56.8%). They also commonly serve individuals of any age with a chronic illness (43.2%), veterans (29.0%), and caregivers (20.0%) through their contracts.

Eighty-six percent of CBOs target high-risk or high-need groups, including individuals at risk of nursing home placement (54.0%); individuals at high risk for emergency room (ER) use, hospitalizations, and/or hospital readmission (48.7%); and individuals who are dually eligible for Medicare and Medicaid (34.7%).

What services and programs are being provided through these contracts?

Figure 4 shows the most common services that CBOs provide through contracts with health care entities: case management/care or service coordination (42%), evidence-based programs (31%), transitions from hospital to home (30%), nutrition programs (30%), and home care (30%).

Figure 4: Most Common Services CBOs Provided Through Contracts



Respondents contracting with any of five specific types of health care partners were asked to indicate which services they provided through these contracts; the top services are displayed in Table 2. Case management, nutrition, and evidence-based programs are common across partner types. Top services that are unique to a specific partner are in red text. For example, Medicaid MCP was the only partner type with home care and institutional diversion/transition in the top services. Mental/behavioral health services and assessment for LTSS were top services only for Medicare/Medicaid Duals plans, and person-centered care and transitions from hospital to home (including readmission prevention programs) were top services only for hospitals or health systems. The same top three contracted services were delivered to both Medicare Advantage plans and ACOs, though in a different order; these included evidence-based programs, case management, and nutrition programs.

Table 2. Services to Specific Contract Partners

	Medicaid MCPs	Medicare/ Medicaid Duals Plans	Medicare Advantage Plans	ACOs/ Health Homes/ CCOs	Hospitals or Health Systems
1	Ongoing case management/care or service coordination	Ongoing case management/care or service coordination	Evidence-based programs	Ongoing case management/care or service coordination	Transitions from hospital to home
2	Home care	Mental/behavioral health services	Ongoing case management/care or service coordination	Nutrition program (e.g., counseling, meal provision)	Evidence-based programs
3	Nutrition program (e.g., counseling, meal provision)	Assessment for long-term services and supports (LTSS) eligibility	Nutrition program (e.g., counseling, meal provision)	Evidence-based programs	Ongoing case management/care or service coordination
4	Institutional transition/diversion (e.g., nursing facility to home)	Nutrition program (e.g., counseling, meal provision)			Person-centered planning

CONTRACT PAYMENT MODELS AND REVENUE

Most contracting CBOs (75.7%) reported that they had one or more contracts on a fee-for-service (FFS) basis (75.7%), such as FFS tiered rate, per service unit, or per service unit plus administration fee. Other payment models were less common, such as per member/per month and other capitation (6.7%), case rate (6.1%), and other time-bound (3.8%).

When asked about the revenue status for each of their contracts, 44.4% of contracting CBOs reported one or more contracts with a budget neutral status, 39.2% had at least one contract generating a profit, 22.9% had at least one contract running a deficit, and 13.9% said one or more of their contracts was not yet generating revenue.

Are CBOs receiving payment for all their contracts?

Three-quarters of the contracting CBOs received payments for all of their contracts with health care entities. The most commonly reported reason for not receiving payment was that the CBO was not yet providing a service for which they could bill (47.2%). A second reason for not receiving payment was issues with the payer's internal process (38.9%), including referrals for services or payment processes.

> *"At one point the [health care entity] owed us about 7 months of program revenue. After following up with various and changing staff at the [partner] we finally figured out we had one code wrong. No one pointed that out… This problem had taken about a million of our cashflow. They got on it right away and together we got it solved. Persistence is key when billing issues arise." – CIL Director*

How common are value-based payments in CBO-health care contracts?

Of the contracting CBOs in this survey, 19.5% had at least one contract with a value-based payment component. Examples of value-based payments include meeting specific targets to receive withhold of payment and meeting outcome measures, such as a reduction of emergency room services and hospital readmissions.

Value-based payment models link reimbursement to quality of services delivered by providing incentives for, and increasing the accountability of, service providers.

Data Collection, Access, and Utilization

What data is being collected and accessed by CBOs as part of their contracts?

Over half (59.6%) of contracting CBOs indicated that they collected CBO program or performance data, and 53.0% had access to this data for any contract. In addition, almost half (49.6%) of CBOs collected data specific to client/patient quality of life, and 43.7% had access to this data for at least one of their contracts.

How are CBOs using the data they collect or access?

About three-quarters of CBOs were using data to improve service/program delivery (76.2%), describe program activities/outputs (75.4%), and ensure organizational compliance with contract requirements (73.1%). In addition, nearly half (47.7%) of responding CBOs with contracts used data to develop a value proposition.

> *"Data collection, organization, reporting, analysis, etc. represents a lot of investment and energy under these contracts, and will require additional data share/integration with health systems and payers, and automation in order to continue to expand and meet payer demands for performance reports." – CBO Director*

CONTRACTING EXPERIENCES

What challenges are CBOs experiencing in establishing and maintaining contracts?

Understanding how challenges related to contracting evolve over the life of the contract can inform Business Institute strategies for mapping outreach, resources, and learning opportunities to the stages of contracting relationships. RFI respondents were asked to identify the top seven challenges they faced when establishing a contract and the top seven challenges they continue to face in their contracting relationship (out of a total of 28 challenges). Table 3 shows that the most common challenges faced by CBOs while establishing a contract were: the time it takes to establish a contract and the negotiation of price and/or contract terms. The most common challenges faced by CBOs following the establishment of a contract included: timely payment for contracted services, competing priorities within the health care community, and denial of claims.

Four challenges appeared as a top challenge in both establishing and continuing the contracting relationship. These challenges (in bold) include: negotiation of price and/or contract terms, staff turnover in the health care entity, timely payment for contracted services, and referrals and volume. Along with the issues with payer internal systems mentioned above as a reason for not receiving payment, this points toward the need for improved referral workflows and contracting language related to volume guarantees.

Table 3. Contracting Challenges

	Was a challenge in establishing the contract (n=133)		Is a current challenge in the contracting relationship (n=133)	
1	Time it takes to establish a contract	39.8%	**Timely payment for contracted services**	30.1%
2	**Negotiation of price and/or contract terms**	37.6%	Competing priorities within the health care community	28.6%
3	**Staff turnover in the health care entity**	27.1%	Denial of claims	28.6%
4	Common understanding of proposed programs/services	26.3%	**Referrals and volume**	27.8%
5	**Timely payment for contracted services**	26.3%	**Negotiation of price and/or contract terms**	27.1%
6	**Referrals and volume**	24.8%	**Staff turnover in the health care entity**	26.3%
7	Contract specificity regarding scope of work, responsibility, and accountability	24.1%	Integration of your organization's service into health care system workflow	23.3%

What changes have CBOs experienced as a result of contracting?

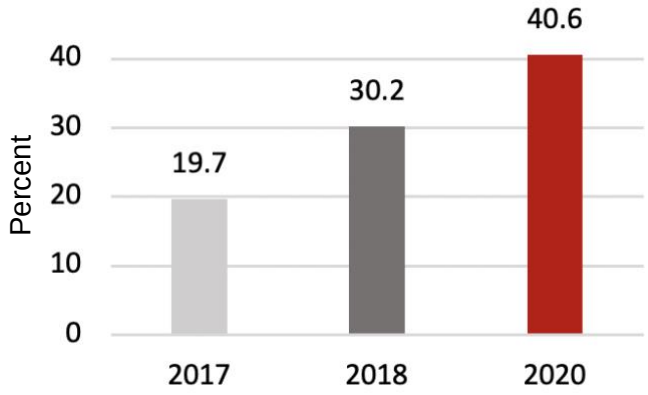
As a result of their contracting efforts, many CBOs experienced changes in their organizations. We asked respondents to identify the top five changes (from a list of 16) that were most significant to their organization. The most commonly reported changes experienced by CBOs were that they were able to: position their agency as a valuable health care partner (42.6%), expand the types of services offered (41.9%), enhance their organization's sustainability (39.5%) and expand visibility of their organization in the community (38.8%).

CONTRACTING AS PART OF A NETWORK

One way that community-based organizations are able to enhance their competitiveness and value to health care partners is by entering contracts as part of a network, or a coordinated group of CBOs that pursues a regional or statewide contract with a health care entity. Networks allow organizations to achieve economies of scale in pricing, marketing, and negotiating contracts.

Contracting as part of a network is increasing among CBOs. Over forty percent (40.6%) 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 19.7% to 40.6%).

Figure 5. CBOs Contracting as Part of a Network, 2017-2020



> *"I think we have done a good job developing a statewide network of AAAs on a contract, from price setting, developing service definitions, and contracting. We are all peers and it is hard to manage a network of peers, but have good directors leading the effort from the aspect of clinical quality, compliance and relationship management."*
> *– State AAA Network Lead*

> *"Our AAA contracts for services with healthcare entities on behalf of all our subcontractors who wish to be part of our network… We provide central intake, billing, back office, legal, compliance, and contracting support. These entities do not have the capacity to enter into healthcare contracts on their own." – AAA Director*

To better understand network characteristics, the survey asked organizations that identified as the **lead** CBO of a network or a managed service organization to provide additional details regarding their network's geographic coverage, model, legal structure, data sharing, and funding. A network lead was defined as an organization that directs the network and facilitates administrative oversight and governance responsibilities. Due to the small sample size, the amount of detailed information gathered about networks is limited; however, it is clear that network characteristics vary greatly.

For example, some networks are comprised of a group of CBOs while others are managed service organizations which operate to manage contracts (including development and negotiation) with health care partners on behalf of CBOs. Some networks coordinate CBO efforts in an entire state while others serve only one region of a state. Some have data sharing platforms for all partners while others have just a data sharing agreement. The examples in Table 4 illustrate network variability.

Table 4. Network Characteristics Examples

	Example 1	Example 2	Example 3
Geographic Coverage	Statewide, in one state	Statewide, in one state	All or part of two or more contiguous states
Model	Joint operating agreement	Shared services	Shared services
Legal Structure	No separate legal structure	Nonprofit LLC structure	No separate legal structure
Data Sharing	Data sharing platform, dashboard, or portal for members as well as a formalized data sharing agreement	Data sharing platform, dashboard, or portal for members	Data sharing platform, dashboard, or portal for members and informal data sharing
Funding	Contracts with health care entities	Contracts with health care entities	Grants/contributions, in-kind contributions from network members, and contracts with health care entities

ORGANIZATIONS PURSUING CONTRACTS

In 2020, 11.7% of responding organizations indicated that they were not contracting but were in the process of pursuing a contract; this is a statistically significant decrease from 16.8% in 2018. In the midst of COVID-19, pursuit of contracts may have become less important as time and energy shifted to ensuring older adults and people with disabilities received the services they needed. Organizations pursuing contracts were asked to identify where they would place their organization along a five-point continuum from exploring the idea of contracts (1) to nearly finalizing a contract (5). As shown in Figure 5, while a quarter of those pursuing contracts are in the initial steps of exploring the idea of contracting with health care entities, a much smaller proportion are very close to finalizing at least one contract, and the majority indicated they were somewhere between these two points.

Figure 6. Progress of Organizations Pursuing Contracts

1	2	3	4	5
Taking the steps to explore the idea of contracting with health care entities		**Engaging one or more health care entiteis in contract discussions**		**Very close to finalizing at least one contract**
25.0%	**28.8%**	**28.8%**	**5.8%**	**11.5%**

Organizations Not Pursuing Contracts

Forty-four percent of RFI respondents reported that they did not currently have a contract with a health care entity and were not pursuing contracts. Of these, over half indicated that they were interested in pursuing a contract with a health care entity but needed more information or guidance before pursuing (35.6%), were interested but not at this time (10.3%), or were interested and had actively pursued contracts in the past that were not successful (5.2%).

Respondents who were not currently pursuing contracts were asked to share information about their organization's position on contracting with health care entities. While some CBOs shared that they do not feel contracting will work with their structure or that they lacked the necessary resources, other CBOs felt that contracting would be beneficial and were hopeful that it would be a future possibility.

> *"It would be wise to work together [the AAA and health care entity] since our clients end up being the same people and we have the same goals of providing services to reduce hospital and pre-mature long-term placement in skilled nursing. Working together would be beneficial." – Rural AAA Director*

> *"[We] currently serve individuals with disabilities with several programs… there are gaps that [we] could help fill in regard to healthcare collaboration [such as] helping consumers stabilize at home and avoid unnecessary hospitalizations and nursing home stays." – CIL Director*

Summary

The proportion of CBOs with these contracts continues to increase. 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. Fee-for-service models are the most common way that CBOs receive payment for their contracts with health care, and nearly one in five CBOs have a value-based component in their contracts. 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 related to program or performance data compared with client or patient data. While some contracting challenges such as a common understanding of proposed programs decrease over time, negotiation, referrals, and staff turnover in the health care entity remain challenges in the contracting relationship. Finally, organizations without contracts typically expressed a need for technical assistance and support, reinforcing the importance of the services and resources provided by the Aging and Disability Business Institute.

ACKNOWLEDGEMENTS

The survey was conducted by Scripps Gerontology Center at Miami University on behalf of the Aging and Disability Business Institute (Business Institute), led by the National Association of Area Agencies on Aging (n4a). The Business Institute is funded by The John A. Hartford Foundation, the Administration for Community Living (ACL), and The SCAN Foundation.

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

The project staff from Scripps Gerontology Center and n4a would like to acknowledge the role of the community-based organizations and the Business Institute Evaluation Workgroup who assisted in the refinement and dissemination efforts of the survey as well as graduate assistants Cheyenne Kinsella and Abbey Bailey at Miami University for assistance with survey administration, data analysis, and report development.

ENDNOTES

[1] AAA organizational data were from the 2019 AAA National Survey. Survey report available at http://www.n4a.org/research

To download this brief report, scan the QR code with your mobile device or go to: https://bit.ly/2020-Strengthening-Ties

SCRIPPS GERONTOLOGY CENTER
An Ohio Center of Excellence

MIAMI UNIVERSITY
OXFORD, OH • EST. 1809

100 Bishop Circle, Upham Hall 396, Oxford, OH 45056
MiamiOH.edu/ScrippsAging.org | 513.529.2914 | Scripps@MiamiOH.edu