Resource Guide

A Health Plan's Guide to Developing CBO Contract Scopes of Work
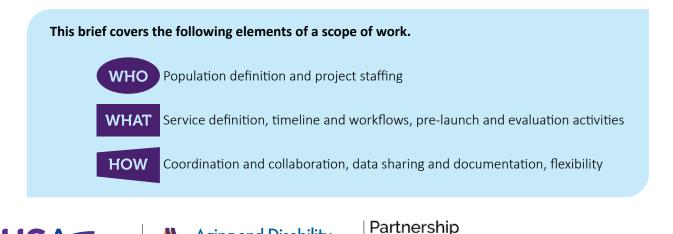
Introduction

Health care organizations are increasingly contracting with community-based organizations (CBOs) and Community Care Hubs (CCHs)[i] to address health-related social needs and provide person-centered services. CBOs are valuable strategic partners to health care organizations because of their community knowledge, the trust they have earned and their long history of delivering critical social care in people's homes and communities.

Many CBO contracts are structured as vendor contracts[ii] for value-added services, care coordination, care navigation or community-based care management. However, as social care and other community-based services become covered benefits or formally approved as in lieu of services (ILOS) under Medicaid or Medicare Advantage supplemental benefits, the health plan may use a provider contract, rather than a vendor contract. Whichever contracting structure is used, the parties must agree upon the core activities, including the who, what and how of the relationship. For the purpose of this brief, we refer to these core activities as the scope of work (SOW) and consider it one of the most important elements of any health care–CBO contract. By investing time upfront in thinking through how the partnership will work at a granular level and documenting such details in the contract, the parties will improve the speed of implementation and the likelihood of successful outcomes for all involved, including the individuals served by the partnership.

Below are recommendations on how to develop an effective SOW, based on insights from health care organizations and CBOs with extensive cross-sector contracting experience. The primary audience for this brief is health plans, though CBOs and other health care organizations including Accountable Care Organizations, clinically integrated networks, and others engaged in value-based payment arrangements or otherwise at risk for health care costs and outcomes can benefit from this brief.[iii]

This brief covers the following elements of a scope of work.

WHO Population definition and project staffing

WHAT Service definition, timeline and workflows, pre-launch and evaluation activities

HOW Coordination and collaboration, data sharing and documentation, flexibility

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Population Definition

There are several elements to defining the population to be served in a contract:

1. Define the eligible population.

   The eligible population is the universe of health plan members who may benefit from this service and therefore could be eligible to receive it. This population should be determined by the problem that the health care organization and CBO want to solve, the evidence base for the service to be provided, and the experience and capabilities of the CBO. It may also be defined by state policy (e.g., Medicaid 1115 waiver) or regulatory filing (e.g., Medicare Advantage supplemental benefit). The defining criteria can include any of the following:

   - Geography of residence
   - Age
   - Clinical condition(s) (e.g., diabetes) or functional status (e.g., nursing home eligible)
   - Social condition/need (e.g., chronically homeless per HUD definition)
   - Health risk (i.e., risk score or algorithm using number of conditions, polypharmacy, etc.)
   - Health insurance type (e.g., Medicaid, Medicare Advantage, etc.)
   - Primary care provider/PCP (e.g., available to patients served by particular PCPs)

2. Volume considerations

   When payment is based on the quantity of services provided, the contract may set minimum and/or maximum service volumes.

   Minimum volume is critical to ensure that plan members eligible for the service are referred to the CBO, and that there is adequate volume to generate a population level impact and adequate revenue to cover the CBO's costs of adding staff and standing up new workflows. The parties should also discuss how the eligible population or their providers will be notified of the availability of the new service in order to ensure adequate service volume. Health plans have found that CBOs are often very effective at conducting outreach and enrollment of potential clients into services.

The parties may limit the volume of people served due to staffing limits or as a way of controlling the funds spent on the contract. When the service population is capped, the contract should define how eligible members are prioritized to ensure equity and maximize effectiveness.

This is an area that the parties should discuss and agree upon, as each partner has access to different types of information. The health plan has claims, ICD codes and risk scores that can inform objective selection and mitigate concerns about equitable access. CBOs know their communities and the types of individuals who are most successful in their programs. Together, health plans and CBOs can identify and direct appropriate members to the point of service. Identifying prioritization criteria is an early opportunity for collaborative learning and decision-making that can help set a positive tone for the partnership.

Types of services

Contracts with CBOs can be for a wide range of services including, but not limited to:

- Assessment for health-related social needs
- Nutrition program
- Community-based care coordination
- Care management
- Tenancy support
- Diabetes prevention
- Diabetes self-management
- Civil legal services
- Medical respite services
- Home care
- Caregiver support
- Transportation
- Transition support

Staffing, Training and Accountability

The scope of work may define who is doing the work on behalf of the CBO. CBOs often provide valuable services using non-licensed individuals like community health workers (CHWs), case workers and peer recovery specialists. The parties should only require licensure when reimbursement or scope of practice requirements dictate. In such situations, the parties may also require such licensed professionals to go through a credentialing process to ensure that their licenses are valid and they are not subject to disciplinary action.

The parties may also agree to other requirements of staff, including specific training, cultural competency, background checks, etc. CBOs may also have specific requirements for their service providers that should be specified.

The parties may also identify one or more point(s) of contact in each organization for each major aspect of the contract (e.g., data transmission and reporting, client referrals, evaluation). The contract should also clarify an escalation pathway to efficiently address problems that cannot be resolved by the teams on the ground. While the parties can always change this based on organizational needs, the inclusion of such information creates greater clarity and efficiency for the parties to be able to quickly resolve issues when they arise.

Defining the Service Provided

Services provided by a CBO can range from identifying and engaging members for purposes of performing a social needs assessment to providing ongoing care coordination services, medically tailored meals, evidence-based programs, home repairs housing supports and more. The intensity, duration and customization of the service will impact the level of specificity required when defining the service. Some services like food delivery are fairly uniform and can be succinctly described in detail. Other services like care coordination have multiple stages and components that can vary depending on the client. More complex services will require descriptions of the various elements and allow for flexibility in how those elements are delivered to a particular individual based on their goals and preferences.

The goals of defining the service are to create shared expectations, predictability and accountability. In a provider contract, when Medicaid or the health plan has already formally defined the service, the provider contract will simply apply that definition.

- In a value-added contract, however, the parties will need to define the service using the following elements. The responsibilities of each party should be laid out in the delivery of services.
  - Initiation of service: Identification, engagement and enrollment of individuals in a service, including verifying eligibility with the health plan.[iv]
  - Provision of service: What does the service consist of? Is there an assessment? Care planning? Where does the service take place (home, clinic, telephone)? Is there a minimum frequency of contact or interaction? What should the timing of the service be (e.g., within 24 hours after hospitalization, etc.)? Are there required or expected milestones?
  - Conclusion of service: Is there a maximum duration of service? What constitutes completion of the program? Are members eligible to receive the service multiple times? If so, are there any restrictions?

Workflows for Contracted Services

The provision of new services delivered by a CBO to health plan members requires both parties to work together in an efficient manner. Together the parties will want to co-design and document the workflow when it comes to the major activities of the contracted services so that there is clarity about each party's roles, responsibilities and activities, and that the flow of referrals and pathway for plan members to access services is documented and efficient. The contract can include the workflow or require that the parties meet to establish a written workflow. For example, the following workflows should be established:

- How the availability of new services is communicated to members and plan network health care providers.
- Who has the responsibility and the mechanisms by which the parties identify potential service recipients, confirm their eligibility and document enrollment in service.
- The mechanism for referral and reporting between a community care hub and its network members.
- Time expectation for initiation and completion of services.
- Service recording, data reporting and billing submission.

WHAT

Pre-Launch Activities and Evaluation

New contracts require preparation and onboarding before services can be delivered. Expectations around pre-launch activities should be established, including:

- Creation of a project management plan to structure the change process
- State or federal program compliance—such as obtaining a Medicaid provider number or a national provider identifier (NPI)
- Credentialing of staff
- Staff training
- Data security review (may be conducted before contract is signed)
- Onboarding of any new technology access or interfaces, including reporting and payment platforms
- Development of workflows for referral and reporting (see below for further details)

These activities require time, effort and resources from the CBO and therefore should be compensated. Compensation can come upfront in a direct payment (which is either recouped from or in addition to future service payments) or be built into the service fees (provided there are volume guarantees and the CBO has adequate cash flow).

The contract should also set expectations (including resources) and a timetable around evaluation activities. Some parties will provide details about the evaluation process up front while others will state that the parties will work together to develop and execute an evaluation plan by a certain date.

Coordination and Collaboration

Successful partnerships require ongoing communication to work through challenges as they arise and identify opportunities for program and system improvements.

- Joint operating committees (JOCs) are collaborative structures that meet regularly (typically monthly) to review data, raise and resolve issues, and celebrate successes. The JOC should include relevant stakeholders from both parties, including leadership, so that the parties can have substantive conversations and make decisions during JOC meetings.

- Many partnerships also use shared case conferencing to advance joint learning and strengthen the partnership. Working through difficult cases together helps both parties understand the complexities of members' lives and appreciate the value that each team contributes. Case conferencing may occur more frequently and involve a smaller group than the JOC, including front-line care managers and service delivery staff.

The scope of work should set expectations about the JOC and shared case conferencing, including who participates, its purpose and its frequency. The parties should quantify the amount of time that will be devoted to preparation and participation in these collaborative activities and ensure that the CBO is adequately compensated for this time in addition to the time spent delivering services.

Data Sharing and Documentation

As part of the development of the health care–CBO partnership, the parties should engage in data systems strategy sessions to identify their respective data-related goals, collection methods, and systems for storage and transfer. Through this exercise, they can identify the data systems that will be used, the data elements that will be exchanged between the two organizations, and the frequency and secure means by which that data will be exchanged. The parties should also identify whether each will have access to the other's technology portals for purposes of viewing, extracting or reporting information. The parties should seek to develop efficient means for the exchange of data and avoid duplicate entry wherever possible.

Data to the CBO/CCH: The parties should determine what information the CBO needs to identify and engage the individual member (e.g. name, contact information, member ID, etc.). Additional clinical information may be required to enable the CBO to initiate services and ultimately to demonstrate impact. This can vary substantially depending on the nature of the services provided by the CBO and their level of data security and IT capacity. The parties will likely need to establish a business associate agreement (BAA) for purposes of sharing data from the payer to the CBO.

Data to the Health Care Organization: The contract should also identify data-reporting requirements for the CBO. Data reporting serves various purposes, including informing other health plan or provider activities (e.g., care management), documenting services for purposes of payment, calculating quality metrics, supporting evaluation and generating shared learning.

Elements to specify regarding data sharing/reporting:
The data-sharing/reporting provisions should consider and address the following elements:

- **Type of data**
  - What information does each party need from the other? What form should it take (structured data, free text, attachments)?
  - What data standards to use (if any)? ICD-10 Z-codes, CPT, LOINC, or bespoke codes co-developed by the parties?
  - Where does the data come from? (Note that the timeliness of data varies. Claims data can be delivered several months after the service, whereas admissions, discharge and transfer data is often received the same day.)
  - Is the data reported on an individual basis or aggregated for monthly reports to inform shared learning, quality improvement and contract monitoring?

- **Timing**
  - How often is the information collected? Each encounter, monthly, beginning/end of service?
  - How quickly does it need to be reported— in real time or will monthly reports suffice?

- **Data exchange**
  - How is the data exchanged? Is it a spreadsheet or other file that is exchanged by Secure File Transfer Protocol (SFTP) or is there a FHIR connection that enables data to be passed between systems for integration?

- **Data-reporting system**
  - Does the data need to be ingested into a system(s) on the health plan side? Can the data be collected on a platform controlled by the CBO?
  - Can the data be collected and shared on a platform that the CBO is already using by generating extract reports or creating an interface to the health plan's data systems?
  - Is there a common platform that the health plan and CBO will use (e.g., through a Health Information Exchange or social care referral platform)?
  - As a last resort, does the CBO need to do double entry by inputting data directly into a health plan system?

- **Shared data analysis**
  - The parties should consider conducting shared data analysis. This requires making the full data set available to all in the arrangement. The collaboration involved is valuable in advancing continuous quality improvement and shared learning.

Because the use of data varies, it is common to have different data reporting requirements (format, mode of transmission and timing) for different data elements. Attention should be given to the most efficient means of collecting and reporting data, recognizing that CBOs may have more limited data management infrastructure than health care organizations.

HOW

Flexibility

When negotiating the contract, the parties do their best to anticipate how an arrangement will work. However, there are many variables (both within and outside the parties' control) that can impact how the partnership works in practice. It is good practice for the parties to have a contract provision that allows for the parties to revisit aspects of the contract (e.g., payment rates, member eligibility, etc.) based on early and ongoing experience to optimize learning and refinement. This is particularly true for new contracts and pilots and serves to protect both parties.

Conclusion

The scope of work constitutes the core of any health plan–CBO contract. Taking the time up front to talk through and co-design the Who, What and How of the strategic partnership is a valuable investment in creating shared expectations and co-designing efficient workflows that can be successfully implemented. Documenting these agreed-upon terms in the scope of work helps ensure that the understanding of the parties goes beyond the few individuals involved in the initial discussions and is shared by all involved.

About the Aging and Disability Business Institute

This publication was produced for the Aging and Disability Business Institute via a collaboration of Partners in Care Foundation, stakeholders of the Partnership to Align Social Care and was authored by the Camden Coalition. Led by USAging in partnership with the most experienced and respected organizations in the aging and disability networks, the mission of the Aging and Disability Business Institute is to build and strengthen partnerships between aging and disability community-based organizations and the health care system. Funded by The John A. Hartford Foundation, The SCAN Foundation and the U.S. Administration for Community Living, the Aging and Disability Business Institute provides community-based organizations with the tools and resources to successfully adapt to a changing health care environment, enhance their organizational capacity and capitalize on emerging opportunities to diversify funding. Learn more at **www.aginganddisabilitybusinessinstitute.org**.

About the Partnership to Align Social Care

The Partnership to Align Social Care, A National Learning and Action Network[v] (Partnership) aims to address social care challenges at a national level by bringing together essential sector stakeholders (health providers, plans and government with consumers) to co-design multi-faceted strategies to facilitate successful partnerships between healthcare organizations and community care networks. The Partnership is a unique national effort to elevate, expand, and support a network-based approach to sustainably addressing individual and community health-related social needs. Learn more at **www.partnership2asc.org**.

About the Camden Coalition

The Camden Coalition is a multidisciplinary nonprofit working to improve care for people with complex health and social needs in Camden, NJ, and across the country. We work to advance the field of complex care by implementing person-centered programs and piloting new models that address chronic illness and social barriers to health and well-being. Supported by robust data infrastructure, cross-sector convening, and shared learning, our community-based programs deliver care to the most vulnerable individuals in Camden and regionally. Through our National Center for Complex Health and Social Needs (National Center), the Camden Coalition works to build the field of complex care by inspiring people to join the complex care community, connecting complex care practitioners with each other, and supporting the field with tools and resources that move the field of complex care forward. Learn more at **www.camdenhealth.org**.

November 2023

Endnotes

i   Community care networks are a rapidly growing model of social care delivery in which a community care hub (CCH) organizes multiple CBOs into a network that covers a specific geography and provides a wide range of services. The CCH provides centralized administrative functions and contracts on behalf of community care network members. For purposes of this brief, we refer to CBOs whether contracting alone or as a CCH on behalf of a community care network.

ii   A vendor contract differs from a provider contract in a variety of ways. A vendor contract typically purchases something relatively unique and includes a scope of work defining the specific services and products being purchased from the CBO; it may include specifications about how, when and how much of the service is delivered. In contrast, a provider contract typically references well-defined covered services that a provider is contracted to deliver and doesn't require a separate scope of work document.

iii   Mechanic, R.E. and Fitch, A., Working with ACOs to Address Social Determinants of Health, Health Affairs, January 12, 2023, available at Working With ACOs To Address Social Determinants Of Health | Health Affairs.

iv   Health plan–CBO partnerships have used a wide range of methods for identifying and engaging members. The health plan may use its member data to generate lists of eligible members and either contact them directly to refer them to the CBO or give the CBO the list for purposes of outreach and engagement. Alternatively, the health plan can provide a full member list for the geography and let the CBO identify those who meet the criteria and engage and enroll them. These options are not mutually exclusive and can be used in combination to ensure that all eligible members receive the service.

v   Partnership to Align Social Care: A National Learning & Action Network, Partnership to Align Social Care (Partnership), September 2022, **www.partnership2asc.org/wp-content/uploads/2022/09/P2ASC_Overview_Slides_Septeber_2022.pdf**