Resource Guide

Partnerships with Community-based Organizations: Opportunities for Health Plans to Create Value

Overview

Health care entities are increasingly recognizing the importance of addressing health-related social needs (HRSN) such as housing, food and transportation to improve health outcomes and reduce costs. Most government health care programs now require health plans and providers to identify and address members' HRSNs as part of a holistic approach to health. Health plans also understand that unmet HRSNs play a large role in health disparities and preventable health care costs.

In communities across the country, Area Agencies on Aging and other community-based organizations (CBOs) provide a vast array of social services including outreach, care management, nutrition support and supportive housing services. Partnering with CBOs is an efficient and effective means of providing essential social care benefits to health plan members, many of whom face significant structural and social barriers, including racism, poverty and isolation.

Historically, health plans have had concerns about contracting with CBOs due to differences in organizational culture, operational infrastructure, geographic coverage and financing.[i, ii] However, many CBOs have developed new capacities to partner effectively with health care payers and providers, either individually or through community care hubs (CCHs) which organize a diverse network of CBOs (known as community care networks) to cover a broader geography, set of populations and services than any one CBO can individually achieve on its own.[iii]

This Resource Guide presents five overarching reasons that health plans should work with CBOs and community care networks as their contracted social care partners.

- **Powerful Innovation Partners:** CBOs offer the expertise and infrastructure to be powerful innovation partners to health plans for social care delivery.
- **Trust with Members:** CBOs foster a local presence and engender trust with members that can strengthen health plans' reputation and enhance their market share.
- **Return on Investment:** CBOs can produce a significant return on investment for health plans.
- **Efficiency in Coverage:** Community care networks, operated by community care hubs, offer health plans greater efficiency and coverage in social care contracts.
- **Securing Public Contracts:** CBO relationships offer health plans a competitive advantage in securing public contracts.

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Powerful Innovation Partners: CBOs Have the Expertise and Infrastructure That Make Them Powerful Partners in Innovation for Health Plans in the Delivery of Social Care Services[iv]

CBOs have expert knowledge about the communities they serve and the social care landscape, which can accelerate health plans' understanding of member needs and the development of strategies to deliver more effective services.

Like medicine, social care is a unique field with its own language, evidence-based models, communities of practice and policy environment. With deep roots in the communities they serve, CBOs are experts in these elements and can help health plans as they seek to integrate social care into their programs and systems. Partnerships with CBOs can accelerate health plan strategy and connection to key social care partners and programs to foster new solutions that bridge health and social care.

CASE EXAMPLE

Blue Shield of California Promise Health Plan wanted to improve maternal health and pregnancy support outcomes for its members. The Senior Medical Director at the time, Chris Esguerra, approached **First 5 Los Angeles**,[v] a nonprofit organization that works to ensure children in California are reaching developmental milestones, to learn how the plan could improve pregnancy health outcomes. First 5 LA quickly educated the health plan on the landscape of community-based programs supporting pregnancy health outcomes and the variety of care models the CBO utilized, such as Nurse-Family Partnership, Parents as Teachers and many others. First 5 LA and Blue Shield of California Promise Health Plan recognized that each partner brought its own expertise and trusted relationships that in combination were greater than the sum of its parts. Working together, they addressed existing barriers and built stronger connections among the community-based programs and local hospitals and health care providers that contributed to their common goal of improving pregnancy outcomes for members. Eventually, First 5 LA became the contracting entity Blue Shield of California Promise Health Plan used for its home-visitation services.

CBOs have well-established care delivery structures, which can help health plans quickly and effectively implement social care programs.

Payers can leverage CBOs' existing infrastructure and services to quickly and efficiently stand-up new programs for health plan members, rather than develop duplicative programs—efforts that take considerable time and investment. CBOs have established staffing, workflows and relationships that can be deployed on behalf of plans to engage members and efficiently provide evidence-based services that address member needs.[vi]

CASE EXAMPLE

The CBO-payer partnership between **New Jersey's food banks and Horizon Blue Cross Blue Shield of NJ**[vii] demonstrates the ability of health plans to leverage existing CBO infrastructure to reach members when launching a new benefit.

Individuals who are food insecure have difficulty accessing nutrient-rich foods, ultimately impacting eating habits and overall health outcomes. Food banks alleviate food insecurity by providing healthy fruits, vegetables, protein and non-perishable options directly to individuals and families through established outreach and distribution strategies. Through its partnership with the community-based food banks, Horizon Blue Cross leverages the food banks' infrastructure for delivering services to plan members rather than spending time and resources to develop new food access programs. In return, Horizon has helped improve the food banks' infrastructure by initiating a pilot program to grow local pantries' knowledge, resources and frameworks for delivering services.[viii]

CBOs are nimble and can pivot quickly to provide the necessary social care services to health plans' members.

Health plans also benefit from CBOs' tenacity and ingenuity to reach populations with the greatest need—populations that are often the most challenging for payers to engage.[ix] For example, during the COVID-19 pandemic, CBOs and health plans quickly pivoted their priorities to address the needs of communities most impacted. Many CBOs had to adapt to deliver existing services in new ways, while also providing new services, including COVID-related community outreach and education, contact tracing, vaccine education and delivery, as well as meal delivery, housing, mental health services and other supports that were not previously part of their day-to-day activities.[x] Health plans partnered with CBOs during the COVID-19 pandemic to leverage CBOs' touchpoints with members outside of traditional health care settings—touchpoints that were more conducive to building trust and produced more successful engagement than health plans' telephonic outreach efforts—to address member needs.[xi] CBOs bring a spirit of innovation and collaboration to their partnerships with health plans and are comfortable working in new ways to identify and overcome challenges as they arise within their communities.

Trust with Members: CBOs Can Foster a Local Presence and Engender Trust with Members to Bolster Health Plan Reputation and Strategy

CBOs have trusting connections with members, which can drive participation in health plan programs for better engagement, retention and member experience.

Health plans recognize that trust is critical in engaging and retaining members, particularly those who face complex health and social needs. Yet in communities that have experienced generations of systemic racism, marginalization and neglect, institutional mistrust is a factor that health plans must overcome to engage and sustainably serve members of these communities.[xii]

Trust between communities and institutions is not transactional; instead, it is earned by a consistent presence in and a demonstrated commitment to the community. While most health plans operate on a statewide or national capacity, and often lack a local presence, CBOs are trusted local stakeholders in the communities they serve. They have strong relationships with community groups, like faith communities, schools and neighborhood institutions, and hire staff and board members directly from the community. Partnering with CBOs can help health plans create a trusted local presence and improve member engagement. As local partners, CBOs can more effectively engage and connect members to other trusted resources, thereby improving member experience. Moreover, health plans gain reputation benefits through their role as partners and financial supporters of CBOs that are well-regarded in their communities.

CASE EXAMPLE

Independent Health, the largest Medicare Advantage health plan and the only locally owned and operated health plan in western New York, partners with the Western New York Integrated Care Collaborative (WNYICC), a CCH, to provide meal delivery to members following discharge from a hospital or skilled nursing facility. The health plan values its partnership with WNYICC because it *"provides a community-based resource that is known to our members and trusted through recognizable partners under the WNYICC umbrella. Members appreciate and engage through meaningful connections provided via access to benefits they otherwise might not have considered using...Members are able to use the benefit during recovery and continue to do so because of the comfort and safety it provides for continued aging in the home. Members also appreciate the value of having someone they can turn to who understands their unique needs as a western New Yorker."* (Dawn Odrzywolski, Vice President, Medicare Programs, Independent Health)

CBOs have a holistic view of plan members and help them gain access to available services and supports to meet their needs.

When CBOs lead care management activities, they leverage the trust they have in the communities they serve to build therapeutic relationships with health plan members—relationships that are essential to setting goals and achieving life changes that improve health[xiii] Through their committed presence in communities, CBO staff cultivate relationships with members that evoke trust, continuity and security. These authentic relationships enable CBO staff to be invited into homes, neighborhood centers and other community spaces to better assess a community's needs as well as its strengths. In-depth knowledge of their clients enables CBOs to effectively navigate and build member self-efficacy to access available supports, including benefits such as the Supplemental Nutrition Assistance Program (SNAP) and peer recovery or job training programs, allowing CBOs to facilitate behavior change that leads to improved member health outcomes.[xiv]

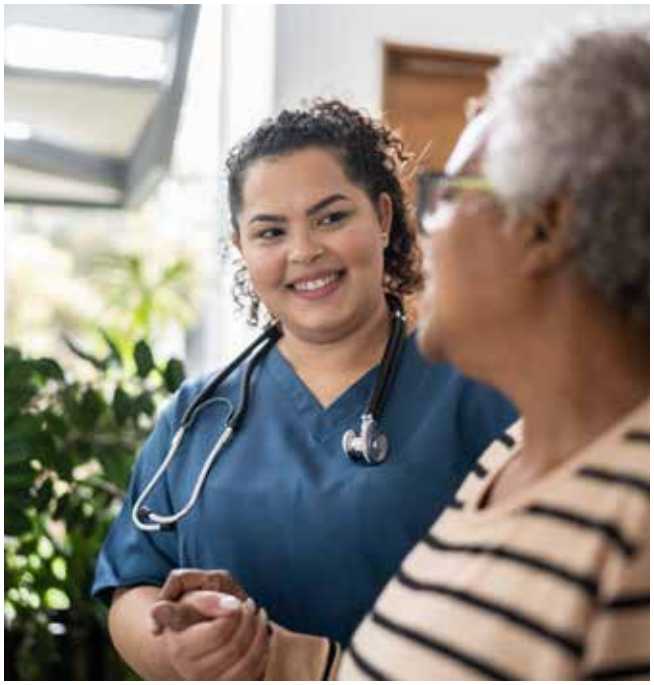
Return on Investment: CBOs Can Produce a Return on Investment (ROI) in Many Different Forms

Social care interventions produce health care savings and service delivery value for health plans.

A growing body of evidence demonstrates the financial benefits of addressing unmet social needs, particularly for populations that rely on expensive acute health care resources.[xv, xvi, xvii, xviii] Studies show that health improvements and cost reductions are associated with various interventions, including providing:

- safe and stable housing (whether medical respite, transitional housing or permanent supportive housing) to individuals experiencing homelessness;[xix]
- medically tailored meals to those with diabetes and heart disease;[xx] and
- home repairs to prevent falls and allow older adults to age in the community.[xxi]

As discussed earlier, CBOs offer operational efficiency as well as the ability to blend and braid public funds to support their programs, which in turn enables health plans to scale new interventions and meet the holistic needs of their members.[xxii]



The **Commonwealth Fund's ROI calculator** is a no-cost tool to aid health plans in understanding and calculating the financial benefits of investing in various social care interventions. Supported by a robust library of evidence, the calculator uses the health plans' data, including its current emergency department, inpatient utilization rates and the estimated costs of services, to produce a customized impact assessment showing changes in health care utilization and the related impact on health plan costs from adopting a social care intervention.[xxiii] Health plans and CBOs have used this tool to document their shared goals and expectations at the outset of a partnership in order to achieve strong leadership support.[xxiv]

CBOs can help health plans achieve higher quality scores, greater market share, and revenue growth.

In addition to direct cost savings, CBO partnerships can achieve improved health outcomes and health plan quality scores. Research shows that social care alignment can improve patient satisfaction, perceived quality of care and access to care—characteristics captured in quality score metrics.[xxv] Quality scores are essential to National Committee for Quality Assurance (NCQA) certification, health plan ratings (e.g., STAR ratings) and member assignment algorithms, all of which generate additional revenue through increased market share.[xxvi]

Efficiency in Coverage: Community Care Networks Offer Health Plans Greater Efficiency and Coverage in Social Care Contracts

Community Care Hubs can help scale and standardize services to health plans while minimizing transaction and contract management costs.

As health plans incorporate social care benefits as a core service area, they must develop a parallel provider network. Many CBOs are experts in service delivery and enjoy deep community connections and trust but lack the operational infrastructure to partner with highly regulated health plans. CCHs enable a wider range of CBOs to participate in health care partnerships by providing shared administrative services such as business development, contracting, compliance and data security, data reporting, billing and coding, and quality improvement to their network.[xxvii]

CCHs provide health plans with contracting and service delivery efficiencies by eliminating the need for multiple smaller contracts and enabling bundled access to an expansive array of services, geographies and populations across members' life spans—allowing plans to scale social service programs.[xxviii] Contracting with CCHs can assist payers with gaining access to local CBOs' deep community connections to engage members while reaping community care networks' benefits, such as higher levels of compliance (data security, audit etc.), standardized services and quality improvement.[xxix]

CASE EXAMPLE

The San Joaquin Community Foundation, a Pathways Community HUB, offers CBOs that hire Community Health Workers (CHWs) support with sponsorship, claims and invoicing, data reporting, contracting and technology platforms.[xxx, xxxi] The United Way of San Joaquin acts as a sponsor for CBOs in the county and the organizer of the Connected Community Network (CCN), an initiative comprised of community partners leveraging a shared technology resource directory and referral platform.[xxxii, xxxiii] The Pathways Community HUB utilizes the CCN resource and referral platform to support CHWs in accessing resources and supporting clients in addressing social needs. The San Joaquin Community Foundation demonstrates how CCHs can improve the efficiency of CBOs through networks, which ultimately will impact contracting processes.

Securing Public Contracts: CBO Relationships Offer Competitive Advantage in Securing Public Contracts

CBO partnerships help health plans compete for contracts and improve market share in publicly funded insurance.

A recent analysis of Medicaid requests for proposals (RFPs) demonstrates that states heavily weigh innovative implementation and management of programs related to member services and population health, such as social determinants of health (SDOH) and health equity initiatives, when awarding contracts to plans.[xxxiv] A history of productive engagement and contracts with CBOs can make health plans more competitive in Medicaid RFPs by demonstrating their commitment to local partnership, member experience, innovation in whole person health and SDOH and health equity.[xxxv, xxxvi]

CASE EXAMPLE

In 2022, California reprocured Medi-Cal services through a competitive request for proposals (RFP) process, which included requirements for health plans to improve health equity, partner with and invest in CBOs and address the SDOH through innovative strategies. The RFP also included "stronger provisions for network providers to understand and meet community needs through local presence and engagement."[xxxvii]

CBOs can support health plan performance outcomes on new and emerging social and medical care measures.

Health care regulators are increasingly incorporating social health measures as required metrics. In 2023, CMS will require health care providers to record the populations screened for SDOH measures and the rates of identified social needs in each category.[xxxviii] Social needs measures are also becoming tied to health plan ratings. NCQA determines health plan accreditation based on medical outcomes and patient experience measures, also known as Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment

of Healthcare Providers and Systems (CAHPS) surveys. In efforts to improve health outcomes, NCQA is adding Social Needs Screening and Intervention (SNS-E) as part of the HEDIS measures—the core of health plan ratingsxxxix. Now, health plans will need to evaluate the percentage of members who were screened for SDOH and those who received an intervention within 30 days of screening.[xl] One can anticipate the addition of new social care metrics over time. CBOs are desirable partners for health plans because they help payers meet social needs goals by virtue of their capacity to look into communities of members to understand and address necessary and desired needs. According to the **Aging and Disability Business Institute's 2021 CBO–Health Care Contracting Survey,** more than 40 percent of CBOs with health care contracts provide SDOH screening and care management to health care providers and payers.[xli]

Looking Forward

Health care in the United States is rapidly moving towards aligning social care services with health care services to address the unmet needs of individuals experiencing complex health challenges. As health plans work to make this a reality for their members, AAAs and other CBOs are essential partners. These organizations possess the trust of communities, expertise about services and systems and program infrastructure to help health plans achieve their health equity, quality and financial goals.

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**[xlii] (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**.

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Endnotes

i National Association of Insurance Commissioners, *Medical Loss Ratio,* October 2022, **https://content.naic.org/cipr-topics/medical-loss-ratio#:~:text=The%20medical%20loss%20ratio%20(MLR,as%20well%20as%20profits%20earned.** The Commonwealth Fund, *Enabling Sustainable Investment in Social Interventions: A Review of Medicaid Managed Care Rate-Setting Tools,* January 2018, **www.commonwealthfund.org/publications/fund-reports/2018/jan/enabling-sustainable-investment-social-interventions-review.**

ii Resources for Integrated Care, *Key Considerations For Health Plans: Partnering With Community-Based Organizations To Address Social Determinants Of Health,* March 2021, **www.resourcesforintegratedcare.com/health_plans_community_based_organizations_address_sdoh**.

iii Scripps Gerontology Center: Miami University, Advancing Partnerships: *Contracting Between Community-Based Organizations and Health Care Entities,* January 2022, **www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2022/03/2022-Advancing-Partnerships.pdf**.

iv National Academies of Sciences, Engineering, and Medicine. *Integrating Social Care Into the Delivery of Health Care: Moving Upstream to Improve the Nation's Health,* 2019, **nap.nationalacademies.org/download/25467**

v First 5 LA, **www.first5la.org**.

vi National Library of Medicine, *Community-Based Organizations' Perspectives on Improving Health and Social Service Integration,* March 2021, **www.ncbi.nlm.nih.gov/pmc/articles/PMC7937223**.

vii Food Bank of South Jersey, *Unique Partnership Aims to Achieve Food Security and Improve Health,* October 2022, **https://foodbanksj.org/unique-partnership**.

viii Food Bank of South Jersey, *Unique Partnership Aims to Achieve Food Security and Improve Health,* October 2022, **https://foodbanksj.org/unique-partnership**.

ix The Commonwealth Fund, *In Focus: Innovating Care Delivery in the Safety Net,* December 2014, **www.commonwealthfund.org/publications/newsletter-article/2014/dec/focus-innovating-care-delivery-safety-net**.

x National Council on Aging, *The Impact of COVID-19 on Community-Based Organizations Serving Older Adults,* March 2021, **www.ncoa.org/article/the-impact-of-covid-19-on-community-based-organizations-serving-older-adults**.

xi United Healthcare, *Community Spotlight: Helping to stop COVID-19 in its tracks in underserved communities,* April 2021, **https://newsroom.uhc.com/community/stop-covid-dc.html**.

xii Springer, *A Qualitative Analysis of Interprofessional Healthcare Team Members' Perceptions of Patient Barriers to Healthcare Engagement,* September 2016, **https://link.springer.com/article/10.1186/s12913-016-1751-5**.

xiii USAging, Aging and Disability Business Insitutte, *Elder Services of the Merrimack Valley and North Shore and My Care Family Accountable Care Organization,* January 2022, **www.aginganddisabilitybusinessinstitute.org/partnership-profile-elder-services-of-the-merrimack-valley-and-north-shore-and-my-care-family-accountable-care-organization**.

xiv Health Affairs, *Health Care and Community-Based Organizations Have Finally Begun Partnering To Integrate Health And Long-Term Care,* February 2018, **www.healthaffairs.org/do/10.1377/forefront.20180130.620899**.

xv The Commonwealth Fund, *Review of Evidence for Health-Related Social Needs Interventions,* **www.commonwealthfund.org/sites/default/files/2019-07/COMBINED_ROI_EVIDENCE_REVIEW_7.15.19.pdf**.

xvi The Commonwealth Fund, *Investing in Social Services as a Core Strategy for Health Care Organizations: Developing the Business Case,* March 2018, **https://institutes.kpmg.us/content/dam/institutes/en/government/pdfs/2018/investing-social-services.pdf**.

xvii The Commonwealth Fund, *Welcome to the Return on Investment (ROI) Calculator for Partnerships to Address the Social Determinants of Health,* **https://www.commonwealthfund.org/roi-calculator**.

xviii Agency for Healthcare Research and Quality, *Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes,* March 2021, **www.ahrq.gov/innovations/hub/index.html**.

xix Health Affairs, *Housing and Health: An Overview Of The Literature, June 2018,* **www.healthaffairs.org/do/10.1377/hpb20180313.396577**.

xx JAMA Network, *Association of National Expansion of Insurance Coverage of Medically Tailored Meals With Estimated Hospitalizations and Health Care Expenditures in the US,* October 2022, **https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2797397**.

xxi North Carolina Housing Finance Agency, *Urgent Home Repair: Quality of Life and Cost Impacts,* November 2017, **www.nchfa.com/sites/default/files/page_attachments/URPPolicyBrief.pdf**.

xxii Economic Studies at Brookings, *Budgeting to Promote Social Objectives—A Primer on Braiding and Blending,* April 2020, **https://www.brookings.edu/wp-content/uploads/2020/04/BraidingAndBlending20200403.pdf**.

xxiii The Commonwealth Fund, *Welcome to the Return on Investment (ROI) Calculator for Partnerships to Address the Social Determinants of Health,* **www.commonwealthfund.org/roi-calculator**.

xxiv The Commonwealth Fund, *Homage: Calculating the ROI of a Partnership to Meet the Health-Related Social Needs of Medicare Advantage Plan Members,* March 2020, **www.commonwealthfund.org/sites/default/files/2020-10/Tabbush_Homage_ROI_Calculator_Use_Case.pdf**.

xxv NCQA, *Health Plan Ratings,* **www.ncqa.org/hedis/health-plan-ratings**.

xxvi California Health Care Foundation, *Putting Quality to Work, Rewarding Plan Performance in Medi-Cal Managed Care, Appendix B,* December 2017, **www.chcf.org/wp-content/uploads/2017/12/PDF-PuttingQualityToWorkAppendixB.pdf**.

xxvii Partnership to Align Social Care: A National Learning & Action Network, *Community Care Hubs: Making Social Care Happen,* December 2022, **www.partnership2asc.org/wp-content/uploads/2022/12/CCH-Primer-Final.pdf**.

xxviii California Health Care Foundation, *The Role of Community-Based Organization Networks in CalAIM: Seven Key Considerations,* August 2022, **www.chcf.org/publication/role-cbo-networks-calaim-seven-key-considerations**.

xxix California Health Care Foundation, *The Role of Community-Based Organization Networks in CalAIM: Seven Key Considerations,* August 2022, **www.chcf.org/publication/role-cbo-networks-calaim-seven-key-considerations**.

xxx **https://sanjoaquincf.wpengine.com/where-we-focus/healthy-communities/pathways-community-hub/**

xxxi **https://www.chcf.org/wp-content/uploads/2022/08/RoleCBONetworksCalAIMSevenKeyConsiderations.pdf**

xxxii Ibid.

xxxiii **https://www.bing.com/ck/a?!&&p=441b9d6d4b76aaa0JmltdHM9MTY5MTUzOTIwMCZpZ3VpZD0wNjJhNTRhYS02NDNjLTYwNmEtMTUyOC00NjEzNjUyNTYxZjkmaW5zaWQ9NTI1NA&ptn=3&hsh=3&fclid=062a54aa-643c-606a-1528-4613652561f9&psq=San+Joaquin+connected+community+network&u=a1aHR0cHM6Ly93d3cuY29tbW9uc3Bpcml0Lm9yZy9jb250ZW50L2RhbS9jb21tb25zcGlyaXQtvcGRmcy9Db21tb25TcGlyaXQtSGVhbHRoX0NDTi1DYXNlLVN0dWR5LnBkZg&ntb=1**

xxxiv Guidehouse, *States are Cultivating a Medicaid Marketplace Where MCOs Must Prove Their Worth,* September 2022, **https://guidehouse.com/insights/healthcare/2022/blogs/medicaid-marketplace-mcos-prove-worth**.

xxxv The Commonwealth Fund, *Forging Community Partnerships to Improve Health Care: The Experience of Four Medicaid Managed Care Organizations,* April 2013, **www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2013_apr_1687_silowcarroll_forging_community_partnerships_medicaid_managed_care_ib.pdf**.

xxxvi Resources for Integrated Care, *Key Considerations For Health Plans: Partnering With Community-Based Organizations To Address Social Determinants Of Health,* March 2021, **www.resourcesforintegratedcare.com/health_plans_community_based_organizations_address_sdoh**.

xxxvii DHCS, *Medi-Cal Managed Care Plan (MCP) Request for Proposal (RFP) 20-10029 Voluntary Pre-Proposal Web Conference,* February 2022, **www.dhcs.ca.gov/provgovpart/rfa_rfp/Documents/RFP-20-10029-Proposer-Conference.pdf**.

xxxviii Fierce Healthcare, *CMS approves first measures to track social determinants at federal level,* August 2022, **www.fiercehealthcare.com/regulatory/cms-approves-first-ever-measures-track-sdoh-federal-level**.

xxxix NCQA, *Why "Sync for Social Needs,"* September 2022, **www.ncqa.org/blog/why-sync-for-social-needs**.

xl NCQA, *Why "Sync for Social Needs,"* September 2022, **www.ncqa.org/blog/why-sync-for-social-needs**.

xli Scripps Gerontology Center: Miami University, *Advancing Partnerships: Contracting Between Community-Based Organizations and Health Care Entities,* January 2022, **www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2022/03/2022-Advancing-Partnerships.pdf**.

xlii 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**.

Resource Guide

A Health Plan's Guide to Paying CBOs for Social Care

Introduction

Payment is a critical element of any contract. When negotiating the payment aspects of a contract between a health care entity and a community-based organization (CBO) or community care hub (CCH), both the amount of the payment and the payment methodology need to be considered. CBOs should keep in mind that there is no single "best" payment methodology that is appropriate in all situations. Rather, it's important to match the various features that define the payment methodology with the nature of the services, relationship between the parties and the goals of the contract.

Over the last decade, the health care entities, driven largely by the Centers for Medicare & Medicaid Services (CMS), have been moving away from their traditional reliance on fee-for-service (FFS) payment and moving toward alternative payment models (APMs). APMs are payment methodologies that create direct financial incentives for providers to improve the quality of care while controlling costs. APMs are intended to be a departure from the volume driven incentive structures in FFS.[i] APMs, such as bundled payments, capitation and shared savings, can include risk sharing and quality incentives at the service, individual or population level. The goal of APMs is to align the incentives of providers and payers to produce the triple aim of improved population health, better experience of care and lower cost.

While much of the U.S. health care system is still centered on FFS payments, the growth of APMs has created new opportunities for partnership and contracting between health care entities and CBOs. Greater financial accountability and incentives can spur health care entities to invest in addressing health-related social needs (HRSNs), which can improve health outcomes and reduce overall spending. Moreover, as health care payments to CBOs accelerate, it's important to leverage the lessons of health care's overreliance on FFS to ensure that CBOs are compensated in ways that generate value for all involved.

Nationally, payment methodologies vary in CBO contracts with health care. Some states have begun introducing fee schedules for defined social care services covered by Medicaid, often with the caveat that they are a floor and not a ceiling and that parties are encouraged to negotiate alternate arrangements.[ii, iii] Capitated payment, where the CBO or CCH receives a per member per month fee to cover eligible individuals within the population, is also becoming more common. The 2021 Aging and Disability Business Institute CBO–Health Care Contracting Survey showed that the percentage of CBOs with contracts being paid on a capitated basis in at least one contract had increased to 30 percent in 2021 from seven percent in 2020.[iv]

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As with the contract overall, the goal of the payment model is to align the parties around shared goals and to produce additional value for each party. For CBOs, the payment structure should advance the CBO's mission and cover at *minimum* the costs to provide the service plus relevant overhead (including the administrative and development costs). For health care entities, the value achieved extends beyond financial, to include improved health outcomes, member/patient engagement, equity and learning.

No payment model can guarantee perfectly aligned value, but different payment models create different incentives and require different inputs and activities, which can either promote or detract from the goal of creating value for the CBO, the payer and ultimately for the individuals being served. Moreover, payment provisions work in concert with other elements of the contract, including data reporting, quality measurements and eligible population to help produce that value.

Special Payment Considerations for CBOs

Contracts with CBOs to provide social care services should reflect several ways in which most CBOs differ from the health care sector:

- **Coding/Billing Standards:** Unlike the health care sector, which has well-established and comprehensive procedure codes that are applicable to nearly all health care services, procedure codes for many social care services frequently do not exist or are not standardized. While there are national efforts to develop social care codes, code-based billing for social care services is in early development[v] and often requires contracting parties to independently define the service being provided. Additionally, certain codes can only be documented by certain providers which could create limitations in workflows and staffing for services provided.
- **Medical Loss Ratio (MLR):** Most health plans are required to spend at least 85 percent of premium revenues on medical services and quality improvement activities. Most social care services are not currently recognized as part of medical spending and therefore come out of a limited administrative budget, which can limit the health plan's ability to spend on those activities. Social care spending is increasingly covered as part of medical spend, including, for example assessments for health-related social needs (HSRNs), care management, social care benefits under Medicaid 1115 waivers, and services that have been approved as in lieu of services (ILOS)[vi]; however, 1115 waivers and ILOS focused on addressing social needs are not widespread across all states. Regulatory requirements may dictate certain coding or other activities to count CBO-contract spending as part of medical loss, which can be administratively burdensome for both the CBO and the health plan.
- **Customary Payment Structures:** Historically, CBOs have often been paid through grants or contracts that reimburse them on a cost basis and do not require them to bill for individual services. Therefore, when entering contract negotiations, CBOs may be less likely to have determined the "fully loaded" unit cost and value of their services. It is vital for health plans and CBOs to work together to determine fair unit costs and pricing so that CBOs can sustain their services with sufficient reimbursement.
- **Risk Tolerance:** While risk-based contracting strategies like APMs are increasingly common in health care, CBOs and CCHs are newer to APMs and may be less able than traditional health care payers or providers to take on downside risk due to smaller organizational budgets, limited reserves, and tighter finances. Carrying risk also must be based on sufficient volume of service population in order to safely spread the risk.

- **Evolving Payment Methodology:** The payment model used in a particular health care–CBO contract may evolve over time. In the initial pilot phase, there may be insufficient information and experience to warrant a sophisticated APM or even FFS. Moreover, if a CBO doesn't have experience submitting claims, it can be helpful to allow the CBO to submit for payment via invoice rather than individualized claims by member because of the risk of denied claims and extended reimbursement cycles. The health plan can then work with the CBO to mature its operations and revenue cycle to enable it to operate under a claims model. Over time as experience, financial stability and trust increases, other payment methods can be established.

Major Payment Models

The following section details common payment models that CBOs can use in contracts with health care. There are several factors that health care organizations and CBOs should consider when determining which payment approach is most appropriate for their specific partnership goals, including:

- The level of financial certainty (expected revenue and cost) for both the CBO and the payer.
- The incentives to the CBO.
- The financial risk for both parties.
- The amount of data/experience required to support the payment model.
- The cost and administrative burden of billing under the model.

1. **Fixed-price contract:** The contract sets a fixed amount as the total payment for the activities and services contained in the contract, regardless of utilization. The contract may set volume targets or requirements. This payment model is predictable for both sides in terms of cost/revenue and administratively simple, but is not dynamic or responsive to the need or demand for services. It typically does not include financial incentives for volume or quality, though nothing precludes bonus/penalty arrangements that do so.

Fixed Price Contract Example

The Camden Coalition launched a new partnership with a NJ-based Medicaid managed care plan (MCP) using a fixed-price contract. The covered services included engagement and intensive care management of up to 30 high risk members with complex health and social needs, as well as providing social determinants of health (SDOH) screening services to members at participating emergency departments and primary care sites. The MCP also enlisted the Coalition to facilitate relationship building and deepening of their network in the region by hosting two site visits and including the MCP in a wide range of community meetings, programming and training. A fixed-price contract enabled the Coalition to dedicate a certain number of resources to managing the new relationship, was easy to administer, and could be easily budgeted by the health plan. The parties anticipate that they would develop a new contract that might have different payment features based on the learning and results of the initial pilot.

When to use:

Fixed price contracts are particularly well-suited to pilot projects or grant-funded projects. Pilots are often focused on creating a proof of concept and learning how the parties should work together. Much of the time and cost of a pilot is in up-front infrastructure development (e.g., establishing the partnership, developing and standing up workflows and technology interfaces, recruiting and training new staff, etc.), which is hard to recoup in a volume-based arrangement (FFS or bundled payment). The fixed price also provides certainty to the CBO to allow them to dedicate staff to this new program. In negotiating a fixed-price contract, the parties should collaborate to ensure that the funding and expectations in the Scope of Work (SOW) are well aligned, including adequate resources for staffing, and standing up new infrastructure so that the project can be successful.

2. **Fee-for-service:** In a fee-for-service (FFS) model, service providers submit claims to payers for each service rendered, regardless of service outcome.[vii] Each service is typically defined in a narrow and discrete fashion, and in a unit size that can be delivered in a single encounter. It is not uncommon to deliver more than one service in a single encounter.

   The health care system is largely moving away from FFS because it incentivizes providers to deliver more services without regard to the value or quality of those services. Nevertheless, it remains the dominant payment model in health care, and as new social care services are introduced, it is often the default payment model. FFS can entail significant administrative costs, particularly for CBOs that aren't used to billing for services. On the other hand, FFS allows for the amount of care (and resources) provided to fluctuate according to need/demand and ensures that the provider receives additional compensation for every client served. It's important that the health plan and CBO work together to develop equitable FFS rates that adequately cover overhead costs in addition to direct service costs.

   As with health care services, the concern about incentivizing providers to oversupply a service without regard to its value is relevant in the social care context. For CBOs, FFS also contains the opposite risk—insufficient volume of individuals to serve. Low volume can harm CBOs by not generating enough revenue to support the infrastructure and staffing they've invested in to serve the payer. Some contractual ways to mitigate volume risks for CBOs and health plans include:

   - Specification of a minimum service volume;
   - Narrow (or broadened) eligibility criteria for the contracted service; and
   - Setting a maximum volume of the service that can be provided.

Fee-for-Service - Phased Implementation

Mid-America Regional Council (MARC) Aging and Adult Services, an Area Agency on Aging in Kansas City, MO, operates a community care hub (CCH) called Community Support Network. The hub contracted with Blue Cross Blue Shield of Kansas City (BlueKC) health plan to deliver meals, educational courses and other social health interventions to individuals with complex social and medical needs under both commercial and Medicare Advantage plans. The parties chose a FFS payment model, but MARC did not have extensive experience submitting health care claims. In the first phase, MARC submitted invoices with a stated number of services, rather than individualized claims by member, to avoid the potential for denied claims and extended reimbursement cycles. In the later phase, the parties transitioned the contract to require MARC to submit individual member claims. This flexibility made for a smoother launch of the program, which

Health plans will need to consider scalability and sustainability of services in this model, particularly if these services are not considered "medical expenses" under MLR, since there is still limited evidence as to the appropriate intensity of service (e.g., how many medically tailored meals per day/week) and the duration of service (e.g., medically tailored meals offered for how many weeks/months) for specific social needs. Health plans can use pilots to better understand the costs for different intensity and duration of services to appropriately plan expenses to scale and sustain services. As the field continues to develop more evidence on the appropriate populations and best dose of different social care interventions, the parties will be better able to define member eligibility and the intensity and duration to ensure that the service is both cost-effective and sustainable over time.

When to use:
FFS may be appropriate for a standardized service that can be produced at volume, such as a medically tailored meal. Such services can be readily defined for the purposes of a standard service code and have a fairly standard cost to produce and deliver, which makes price negotiation easier.

3. **Bundled payment:** The bundled payment model provides a single payment as reimbursement for an entire suite of services included in a person's care, often described as an episode of care.[viii] It is designed to create accountability in one provider for all of the services needed by the patient for a particular condition during a particular length of time, and generally includes quality/outcome metrics that are tied to the payment. It gives the provider flexibility and incentivizes delivering a combination of services as efficiently and cost-effectively as possible without regard for maximizing FFS revenue volume but does put the CBO at risk if the cost of properly serving the client exceeds the payment amount.

   Designing equitable bundled payment amounts will require adequate data and experience on the part of both parties. In a bundled payment, the parties need to define:

   - The beginning and end of a given episode of care,
   - Which beneficiaries are eligible for the episode,
   - Which services are included in the bundled payment, and
   - Which services will continue to be paid for separately.

Bundled Payment Example

MARC's Community Support Network used multiple payment models in its contract with BlueKC health plan. In addition to paying for meals, courses and other distinct services through a FFS rate, the parties chose a case rate (bundled payment) for the case management services for up to three months, with an option for approved renewal periods. The bundled payment offers more efficient billing for a range of different case management services than submitting separate claims for every contact.

When to use:
Bundled payments may be appropriate for complex services with multiple components delivered over an extended period of time (e.g., care management services, housing support services and care transitions services). In such situations, bundled payment is less administratively burdensome than FFS because each discrete service doesn't need to be separately submitted; it also allows the CBO greater financial flexibility to provide whatever combination of services is most appropriate for the particular client and encourages greater integration and efficiency.

4. **Capitation:** The capitated payment model is structured as a fixed payment given to a provider to cover the costs of care per covered individual per unit of time (e.g., per member, per month [PMPM]).[ix]

   Capitation creates financial certainty for both parties but involves a high level of risk around the volume of services. If volume is low, the health plan gets less value; if volume is high, the CBO incurs additional costs. Capitation incentivizes the CBO to provide service as efficiently as possible. Payers may want to incorporate quality measures or other checks to ensure that the CBO serves all qualified individuals with the full service.

   Capitation is relatively easy to administer from a payment standpoint (it does not require individualized billing like FFS or bundled payment) but requires data and experience for both parties to understand the likely volume, cost and value of the services.

Capitation and Shared Loss Example

In Virginia, BayAging, a community care hub, contracted with a Medicaid managed care plan to provide fully delegated care management for Medicaid enrollees. Bay Aging is paid on a PMPM basis. The parties also agreed to a value-based arrangement in which the CCH would share penalties if they failed to achieve state-required metrics and compliance elements. The penalties, which would be imposed by the state Medicaid agency, started at $1,000 for the first occurrence and increased in 5 percent increments for subsequent occurrences.

BayAging was responsible for achieving state-directed measures, including care plan development, documentation of discussion of person-centered care goals, reduction in all-cause hospital readmissions and vaccine administration.

When to use:
Capitation may be appropriate when the CBO provides a service (or services) that can be delivered at scale for the attributed population, and when both parties have sufficient information to price appropriately. It requires the CBO to have or create the capacity to serve all potential clients, and has the benefit of financial certainty that enables the CBO to invest in additional staff or other capacity.

Pay for Performance

In addition to the four major payment models, contracting parties can include pay for performance features to better align incentives between the payer and CBO or CCH. These financial incentives can operate as both rewards and penalties. The incentives can also be awarded in addition to the underlying payment model or can be "net" of the underlying payment (i.e., the payments already made are subtracted from the shared savings).

Hybrid FFS/Capitation Example

Western New York Integrated Care Collaborative (WNYICC) has established a hybrid FFS/capitated arrangement with Independent Health Medicare Advantage plan. The plan pays a lump sum upfront capitated payment to WNYICC to provide two weeks' worth of home-delivered meals that are delivered to any member who is discharged from the hospital with at least one overnight stay and accepts the service. The plan also pays WNYICC a per meal amount for each day of meals (two meals per day) served per member. The FFS payments are calculated monthly, and if they are less than the capitation payment, no additional FFS payment is made. If, however, the FFS payments exceed the capitation payment, the plan pays the balance as a supplemental payment. WNYICC subcontracts the meal delivery to nine local CBO home-delivered meals partners. This arrangement ensures that WNYICC has adequate cash on hand to pay subcontractors and guarantees sufficient revenue to cover fixed costs. The plan appreciates having a community care hub manage all post-discharge meals at a predictable cost for the year and having one contract to reach all of their beneficiaries throughout an eight-county region.

Shared Savings

Shared savings is a form of bonus often used in Contracts with Accountable Care Organizations (ACOs) and other providers in which the provider receives additional financial payments for achieving reduced overall costs for the population served while maintaining or improving quality measures. Shared savings can involve complex methodologies, since they typically require the parties to calculate actual total costs as well as a counterfactual projected cost. Shared savings are more appropriate if the service is expected to have a significant impact on the population's total cost (e.g., supportive housing, care coordination, etc.), but may be less appropriate if the type of service provided is expected to have a relatively small impact on total cost. A challenge of shared savings and shared losses is to tease out the impact of social needs from other health care factors and interventions.

Shared Savings Example

United Healthcare (UHC) and the Camden Coalition (Coalition) have had a series of partnerships in which the Coalition provided intensive care management for members with a history of high health care utilization as well as practice-based care coordination activities for less complex members through seven primary care practices that work with the Coalition. The contract provided a guaranteed fixed annual payment that covered the care management services as well as a shared savings arrangement that incentivized improved quality and reduced cost. At the end of each year, the Coalition and UHC together calculated the total cost of care for the attributed population (those living in certain zip codes and attributed to the practices that work with the Coalition) and compared it to the projected spend. The Coalition would earn a bonus of 40-50 percent of the calculated savings (after netting out the guaranteed payment). The exact percentage of savings earned was based on seven quality metrics, including patient satisfaction, post-hospitalization follow-up visits, initiation of prenatal care and cancer screenings.

Shared Losses

Downside risk involves the provider sharing in losses or forfeiting part of their payment if they do not achieve certain goals (financial or quality). This can take the form of shared losses if expenses exceed a predetermined benchmark amount. In other contracts, a portion of the compensation will be at risk if a provider doesn't achieve certain quality or outcome measures. Shared losses have the same challenges as shared savings regarding sufficient size of impact and attributing causality. Moreover, many CBOs do not have the financial capacity to bear downside risk, but these provisions may become more common among CBOs who provide services with a clear financial ROI and the level of capital needed to manage downside risk over time.

Outcome-Based Payment

An outcome-based payment involves paying a negotiated amount for each client who reaches a defined outcome. For example, the standard contract for a Pathways Community HUB involves payments for sustainably addressing a health or social risk factor by closing a health/social need gap (e.g., food security, safe and stable housing, obtaining a medical home, etc.). The relative amount of each outcome-based payment has been developed based on experience with mitigating individually modifiable risk factors and extensive evidence of the financial value of addressing that social need.[x, xi] Outcome-based payments provide significant incentive to ensure outcomes but also presents financial risk to CBOs, particularly if it is the only form of compensation, because CBOs incur costs even in situations when the outcome isn't achieved despite the best effort of the CBO. Outcome-based payments can also be used in combination with up-front capital in programs like pay for success.[xii]

Outcome-Based Payment Example

In Ohio, Buckeye Health Plan (a division of Centene) contracted with the Northwest Ohio Pathways Community HUB (HUB) for care coordination provided by community health workers in 13 agencies contracted through the HUB to address health and social risk factors. Payment in the Pathways Community HUB Institute® (PCHI®) Model is attached to confirmed engagement (i.e., home visit) and addressing personally modifiable health and social risk factors defined by the 21 Standard Pathways (i.e., housing, social service referral, medical home, etc.). PCHI® has assigned each Pathway a standard number of outcome-based units (OBU), weighted based on the average time and complexity it takes to complete a Pathway. The HUB received 50 percent of its payment for performing engagement activities (home visit) and the remaining 50 percent based on completing one or more Pathways. The HUB and health plan negotiated a financial rate for each OBU. Buckeye calculated that the HUB reduced overall spending by $2.36 for every $1.00 spent on the HUB. For more information on the Pathways HUB payment model, see **Our Model | Pathways Community HUB Institute | PCHI | United States (pchi-hub.org)**.

Performance Bonuses

To incentivize certain quality measures or other goals, the parties can create a performance bonus tied to certain quality or outcome measures, without having to undertake the complex data analysis of a shared saving calculation. Shared savings can also be calculated in a constructed manner, based on average cost savings from performing certain interventions or achieving certain outcomes, rather than analyzing the actual costs of the particular population.

The following metrics were the most common cited in the 2021 Aging and Disability Business Institute CBO–Health Care Contracting Survey:

- Number of clients served or service units provided (70 percent),
- Accuracy of documentation (44 percent),
- Submission of data reporting (i.e., pay for reporting) (39 percent),
- Timeliness output measures (time to initiate service, time to reassessment, etc.) (33 percent),
- Program/member engagement rate (14 percent).[xiii]
- Parties may want to consider other metrics such as member satisfaction with services, outcome measures, etc.

Flexible Funds

Separate from the way in which the CBO is compensated for its service, health plans often enable CBOs to serve as intermediaries to provide resources directly to members to address crisis needs. Many health plans provide a flexible member needs fund that CBOs can use to provide a gift card or directly purchase goods for the member, such as food, utilities, gas or a taxi voucher. By allocating a per member amount, the health plan and CBO can collaborate to provide short term financial assistance to members outside of the plan's normal procurement process or government's bureaucratic public benefit processes to address a crisis situation and hopefully avoid an Emergency Department visit or other poor outcome.

Payment Model Summary

Feature	Fixed price contract	Fee-for-service	Bundled payment	Capitation	Pay for performance
Financial risk to CBO	Low	Low	Medium	High	Medium
Financial risk to payer	Low	High	Medium	Low	Medium
Complexity for parties to establish price	Low-Medium	Medium	High	High	Medium-High
Cost/complexity of billing	Low	High	Medium	Low	Medium-High
Incentive for CBO to maximize volume	Low	High	Medium	Low	Low
Incentive for efficiency	Medium	Low	High	High	High
Incentive for quality	Low-Medium	Low	Medium	Medium	High

Conclusion

When selecting a payment methodology, there are many considerations that need to be prioritized and balanced to achieve something that is fair, efficient and incentivizes the shared goals of both parties. The parties should consider what is realistic based on their respective ability to take risks and their level of knowledge/confidence about cost, value and volume. For example, while capitation may ultimately be the best payment model for a particular contract, the parties may need to start with a fixed payment or bundled payment structure in order for the parties to gain greater understanding and data before an appropriate capitation arrangement can be developed. Similarly, the parties can use other parts of the contract, including eligibility criteria, approval authority, quality measurement and evaluation to mitigate concerns about excess volume and achieve quality goals.

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**[xiv] (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**.

October 2023

Endnotes

i Value-Based Payment as a Tool to Address Excess U.S. Healthcare Spending, Health Affairs (December 2022), available at **https://www.healthaffairs.org/do/10.1377/hpb20221014.526546/**.

ii The Cal-AIM initiative supports contracting partnerships between payers and social care providers for health-related in lieu of services (ILOS) such as housing, home modifications, food and nutrition, etc. To support these new relationships, the Department of Health Care Services (DHCS) encourages and provides guidance on non-binding pricing for ILOS. Non-binding pricing is suggested as rate variations are influenced by program structure, staffing ratios, facility size, geography and payment models. More information on rate variations is available at **https://www.dhcs.ca.gov/Documents/MCQMD/ILOS-Pricing-Guidance-Updated-8-5-2021.pdf#:~:text=The%20Cal-AIM%20initiative%20and%2C%20in%20particular%2C%20the%20introduction,It%20offers%20information%20on%20potential%20rates%20for%20each**

iii The North Carolina Healthy Opportunities pilot provides a fee schedule for services as guidance for participating organizations. The fee schedule structure accounts for frequency, duration, setting and minimum eligibility criteria for each service. More information on rates is available at **https://www.ncdhhs.gov/media/14071/open**.

iv Scripps Gerontology Center, ***Advancing Partnerships: Contracting between Community-Based Organizations and Health Care Entities,*** January 2022, **https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2022/03/2022-Advancing-Partnerships.pdf**.

v The Gravity Project is a national public collaborative focused on developing health and social care interoperability data standards for social determinants of health (SDOH). The collaborative's goal is to facilitate data sharing and payment for care across organizations and providers. More information available at **Gravity Project (thegravityproject.net)**.

vi On January 4, 2023, CMS issued guidance on coverage and treatment of non-medical services "in lieu of" medical services. **SMD 23-001 - ILOS (medicaid.gov)**.

vii **www.healthcare.gov/glossary/fee-for-service/#:~:text=Apercent20methodpercent20inpercent20whichpercent20doctors,paidpercent20forpercent20eachpercent20servicepercent20performed**.

viii Bundled Payment, American Hospital Association, **www.aha.org/bundled-payment/bundled-payment**.

ix **https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/resident-career-counseling-guidance-and-tips/understanding-capitation**.

x Agency for Healthcare Research and Quality, *Pathways Community HUB Manual: A Guide to Identify and Address Risk Factors, Reduce Costs, and Improve Outcomes,* January 2016, **www.ahrq.gov/sites/default/files/wysiwyg/innovations/CommunityHubManual.pdf**.

xi Association of Maternal and Child Health Programs, *Pathways Community HUB,* **www.amchp.org/wp-content/uploads/2021/05/Pathways-Community-HUB.pdf**.

xii What is Pay for Success? Social Finance, **www.socialfinance.org/what-is-pay-for-success**.

xiii Scripps Gerontology Center, *Advancing Partnerships: Contracting between Community-Based Organizations and Health Care Entities,* January 2022, **www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2022/03/2022-Advancing-Partnerships.pdf**.

xiv 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**.

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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WHO

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

WHO

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.

WHAT

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?

WHAT

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.

HOW

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.

HOW

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**

Resource Guide: Scope of Work Checklist

	Contract provision	Present	Comments
WHO **Population definition**	Eligible population	Yes/No	
	Prioritization criteria, if applicable	Yes/No	
	Service volume–min/max	Yes/No	

	Contract provision	Present	Due Date	Comments
WHO **Staffing licensure, training and accountability**	Required staff licensures, if applicable	Yes/No		
	Credentialing process for staff	Yes/No		
	Staff trainings	Yes/No		
	Organizational contacts	Yes/No		
	Escalation pathway	Yes/No		

	Contract provision	Present	Comments
WHAT **Defining the service provided**	Service activities	Yes/No	
	Service initiation, duration and termination	Yes/No	
	Service setting	Yes/No	

	Contract provision	Present	Comments
WHAT **Workflows for contracted services**	Workflows for major activities	Yes/No	
	Escalation process	Yes/No	

	Contract provision	Present	Comments
WHAT **Pre-launch activities and evaluation**	Credentialing process	Yes/No	
	Staff training	Yes/No	
	Data security review	Yes/No	
	IT application onboarding	Yes/No	
	Referral and reporting workflow development (if not specified in SOW)	Yes/No	

	Contract provision	Present	Comments
HOW **Data sharing and documentation**	IT platforms to be used by parties	Yes/No	
	Data reporting requirements to health care partner- what, when, how	Yes/No	
	Data shared with Community-Based Organization/Community Care Hub- what, how, when	Yes/No	

	Contract provision	Present	Due Date	Comments
HOW **Flexibility**	Revisit contract terms mid- contract	Yes/No		

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Aging and Disability BUSINESS INSTITUTE
Connecting Communities and Health Care

Partnership to Align Social Care
A National Learning & Action Network

Camden Coalition

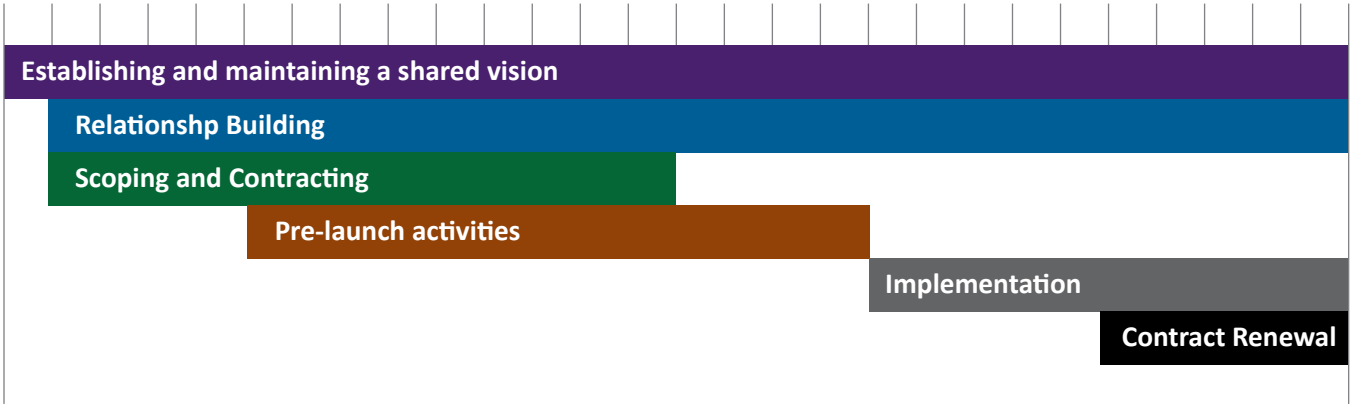
Resource Guide

Operationalizing Contracts: How Payers Can Improve Collaboration with Community-Based Organizations

There is tremendous opportunity to create shared value when health plans and community-based organizations (CBOs) build collaborative relationships to address health-related social needs (HRSNs).[i] However, differences in organizational infrastructure and culture can complicate the development and implementation of successful partnerships, in some cases leading to protracted contracting, misalignment or duplication of services, and insufficient collaboration.[ii, iii]

To address these challenges, this resource outlines recommended practices across the lifecycle of partnership development between health care organizations and CBOs. The brief is written for health plans, though other health care organizations, including accountable care organizations (ACOs), clinically integrated networks and others engaged in value-based payment strategies, may benefit from its wide range of practical strategies for all parties involved to optimize the partnership. No single partnership is expected to use all of these strategies, but any partnership can employ many of these tools to anticipate, avoid and respond to common challenges that arise when CBOs, community care hubs (CCHs, or hubs)[iv] and payers set out to work together.[v]

Figure 1. Contracting Activities Timeline



This resource provides partners with methods for optimizing their relationships in five contracting areas.

- **Establishing a shared vision** allows organizations to discuss why each is investing in the partnership and what shared success can look like. The goal is to align priorities and identify potential areas of divergence to ensure realistic expectations for deliverables and outcomes.
- **Scoping** is a process of co-design to translate a shared vision into operational components (i.e., member eligibility, service elements, data reporting), which are documented in a written contract. Each party can identify their specific needs and work together to resolve disagreements.
- **Pre-launch** activities can put the partnership on a solid path to achieving the shared vision. Best practices for pre-launch planning are collaborative and ensure the CCH/CBO and payer are engaging in open dialogue about barriers to pre-launch activities and beyond.

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- **Implementation and continuous improvement** phases create opportunities to review current implementation processes and use data to understand barriers and opportunities to improve program performance and advance the shared vision.
- **Contract renewal** discussions allow both parties to evaluate what is working well and how the partnership can grow.. This final phase of the contract should offer partners the opportunity to celebrate shared accomplishments and plan to promote lessons learned to relevant stakeholders.

Establishing a shared vision

Establishing a shared vision for the health care–CCH/CBO partnership is a critical first step. This stage represents an opportunity to discuss why each organization is investing in the partnership and what shared success looks like.[vi] The goal is not only to align priorities, but also to identify potential areas of divergence to ensure realistic expectations for deliverables and outcomes.

Differences in CBO and health plan organizational cultures can lead to different perspectives and expectations around risk tolerance, communication, operations and measuring success. It can be valuable for leaders of each organization to explicitly acknowledge these dynamics and normalize differences of approach that may arise throughout the partnership.

The vision-setting process ideally begins before the scope of work is written and can include human-centered design activities, as described below:

Methods for establishing a shared vision

Establish site visits and opportunities for teaming

In-person visits enable teams to learn more about each other's staff, culture and community. Planning a site visit encourages teams to collaborate even before the contracting process begins. During these visits, payer staff can meet CCH/CBO staff to discuss the programmatic data, operational details and value of the work, or to attend local events to understand the CBO's role within the community. Site visits also allow teams to get to know each other, develop authentic connections and build trust that will carry them through the partnership. Hearing members'[vii] stories and what matters to them can help bring to life the impact of the work and inform a shared vision of success.

Create time to acknowledge each partner's organizational cultures

Organizational culture is dynamic and constantly developing based on social and behavioral norms, expectations, and values of staff, leaders and society.[viii] [ix]Organizational culture influences the priorities of leaders and staff, including how they approach new opportunities and solve problems. Exploring differences in organizational culture[x] allows the payer and CBO to better understand how each views the work. This can lead to open dialogue about pressures and constraints and, also, organizational strengths. Partners can utilize their organizational strengths to optimize contract responsibilities, create empathy and promote creative problem-solving.

Develop a shared design process for the partnership

As the parties identify a shared vision and gain a deeper understanding of their respective strengths and values, they can develop the program using an inclusive, human-centered design process.[xi] A cross-section of individuals representing contracting, clinical and programmatic functions should inform priorities, set short and long-term goals, and align on key metrics.

Co-designing programs sets a collaborative tone, leverages each party's strengths and allows scenario-planning for tension points that may arise. The process should cultivate a healthy balance between promoting

the shared vision and acknowledging the reality and constraints of each partner. Jointly developing the workflow can help identify differences that need to be addressed. For example, CBOs may face volume or scaling constraints that are not negotiable at the start of the contract. Payers may not agree to metrics that are impossible to track within their infrastructure or don't align with institutional priorities. In addition, each partner may have their own legal and compliance frameworks to navigate. While the co-design process should focus on what the parties want to achieve, it is best practice to consider the constraints before the official contracting process begins.

The process can include facilitated sessions anchored in the shared vision and values of the partnership and can also use asynchronous methods to gather input and feedback as the concept crystallizes (e.g., circulating drafts for review). Leadership input into the process, and strategic inclusion of leadership in sessions, can support continued investment; however, working sessions or feedback mechanisms without leadership present can also surface different perspectives and ideas.

Scoping

Scoping is a process for translating the shared vision into the operational components of the partnership (i.e., member eligibility, service elements, data reporting and payment), which are documented in a workflow and then a written contract. Each party can identify their specific needs and work together to resolve disagreements. There may be instances where partners must abide by specific scoping and financing criteria. But as much as possible, the payer should be open to deviation from its standard health care vendor risk assessment workflow and contracting processes to facilitate program innovation.[xii]

When payers contract through CCHs, hubs centralize administrative functions such as billing, reconciliation, incident escalation, referral processes , data-sharing, and other contracting activities. This centralization benefits both payers and CBOs by mitigating responsibilities associated with administrative coordination for the plan and allowing CBOs to focus on program delivery and member needs. CCH arrangements convene different partners and services that strategically increase payers' access to CBOs of diverse sizes and specialties, allowing plans to broaden their scope of program delivery.

Whether contracting with an individual CBO or through a hub, when the scope is jointly developed between partners, it more accurately reflects the capacity and needs of both parties and can be more achievable.

Our previous publications can help with this process. *A Health Plan's Guide to Developing CBO Contract Scopes of Work* provides expert guidance on the major components of a scope of work, while *A Health Plan's Guide to Paying CBOs for Social Care* provides guidance on matching payment methodology to the specific goals, services and circumstances of the partnership.[xiii, xiv]

Methods for effective scoping

Define roles

Due to the complexity of payer operations, role definition is a critical piece of the scoping phase, and it can be helpful to take a systematic approach to this exercise. Using process mapping, parties can document major activities and interactions between partners at each stage of member interaction (i.e., identification, engagement, enrollment, service provision, service completion). This process can identify the points of intersection with other health plan functions, such as enrollment, care management, utilization management, and billing and payment. In CBO-payer partnerships, the parties should ideally establish one point of contact from the health plan who is responsible for coordinating with the CCH/CBO program team to triage and address member needs—as well as other issues that arise during program implementation—to ensure efficient and timely collaborative problem-solving. When payers work with CCHs to coordinate partnerships, hub staff take on the lead role of communicating with and training their member CBOs.

In general, collaborating to create new strategies for communication in this area is essential, as workflows are not standard across partnerships and will vary depending on the CCH/CBO's method for handling member lists or referrals. Defining roles will serve as an opportunity for both teams to develop a deeper and more concrete understanding of each other's work, which is helpful in ensuring that the contract scope is feasible.

NOTE: Some parties will elect to engage in more granular role definition and workflow development after the contract is signed but before service launch. The timing is less important as long as there is documented clarity among the parties before beginning service delivery. Both parties should anticipate and be open to changes as the collaboration unfolds.

Engage in data systems strategy sessions

Data-sharing and data collection are critical inputs into a collaborative workflow. To understand programmatic impact and outcomes, the CCH/CBO can contribute program data, while the payer can share information about claims and utilization. One best practice is for parties to engage in data 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, whether and when individual consent or authorization is required and the frequency and secure means by which that data will be exchanged. Parties should also discuss and decide whether each will have access to the other's technology portals for viewing, extracting or reporting information.

Although the ideal is to integrate systems, many constraints exist around achieving interoperable and seamless exchange of data across platforms. As such, both parties will likely have to make trade-offs as they formulate a shared data systems strategy. Since the interim data solution will likely not be perfect, it is important to acknowledge the additional work that will fall on each partner as a result, and name potential inefficiencies that may have implications for service delivery. For example, if one party agrees to double-document, use multiple platforms or reformat data to align with the other's system, remember to allocate sufficient staff time and funding, and/or adjust volume goals.

Acknowledge challenges and establish flexibility around standard vendor processes

Data security practices vary across CBOs, which require health plans to consider flexible data compliance requirements when approaching social care relationships, rather than defaulting to the highest standard. A payer should initiate conversations around data security and compliance soon after the CBO is identified as a potential partner to allow ample time to evaluate the current data security practices, the CBO's capacity to enhance their security level, and negotiations around the payer's ability to adjust their standard requirements based on relative risk. If an annual data security review is required, this should also be discussed soon after identification to allow the CCH/CBO sufficient time to allocate the resources needed to carry out the review.

CCHs offer an attractive alternative to contracting individually with CBOs because they can achieve high levels of data security and compliance on behalf of a network of CBOs and streamline administrative, security and financing processes by providing a consolidated point of contracting, billing and data sharing.[xv]

Strengthen CBO infrastructure

Both parties may identify infrastructure areas, such as data security, technology, patient health information management or staffing, that need to be bolstered prior to implementing the work. This is an opportunity for the payer to support the CBO in making improvements that enable compliance with payer requirements and build long-term capacity with the partner. For example, payers who invest in building a relationship with a CCH can strengthen and compliment the infrastructure of their CBO partners to meet high contracting standards by funneling or supporting administrative, security and data functions through the hub.[xvi]

Pre-launch activities

Any new partnership requires certain onboarding activities before services can begin. Payers and CCHs/CBOs that dedicate attention and time to pre-launch activities can put the partnership on a solid path to achieve the shared vision. Best practices for pre-launch planning, outlined below, are collaborative and ensure the CCH/CBO and the payer are engaging in open dialogue about barriers and how to resolve them through pre-launch activities and beyond.

During the pre-launch activities, the payer and the CCH/CBO may want to complete the following tasks:

- Credentialing of CBO staff
- CBO/health plan staff trainings
- Data security reviews (can also be conducted before the contract is signed)
- Onboarding any new technology access or interfaces
- Development and testing of workflows for referral, reporting and payment/billing
- Releasing pre-payment funds to the CCH/CBO for staffing and technology infrastructure development

Methods for collaborative pre-launch planning

Establish effective communication pathways

Parties may want to develop regular communication practices, such as a joint operating committee (JOC) and case conferencing (see below for further discussion), that enable them to review progress together and learn from the experience of working with individual members. During pre-launch, the parties should establish the details of communication pathways, including cadence, reporting structure and staffing. Creating a standard format for each type of communication, such as standing agendas, slide decks or reports, can create an efficient structure, allowing the parties to focus on the content than the logistics of scheduling and overly burdensome preparation.

Align on member communication and referral processes

It is critical that parties align on and coordinate how they will communicate with members about the partnership, availability of new benefits and referral processes. If done well, this will create clarity, avoiding the confusion of members receiving multiple phone calls or conflicting messages from different parties. Payers often rely on written communication sent directly to members or through primary care providers on new benefits and services. Such written communications can be used to introduce and feature the relevant elements of the partnership's new offerings.

Effective co-design of referral processes will allow the parties to clearly map how members will be connected to the CBO's programming (e.g., portal alerts, provider connections, member lists, emails, phone calls). They will also define enrollment or intake protocols, and how, when and what information is documented and sent to the health plan team. Alternative forms of communication, such as encrypted email or Excel files, can be used to work around portal or system-access barriers and ensure the payer, CCH/CBO, providers and external partners are aware of member referrals in a timely manner. CCHs/CBOs can even help supplement communications strategies by using community-based channels that inform CBOs and other organizations that regularly interact with the population of focus.

It is important to note that this coordination is just as important as the service delivery itself. It is complex and difficult to implement, and it may not work smoothly at the start. The introduction of the CCH/CBO may create some friction with existing payer workflows and practices. Individuals on each team may feel territorial or wary about potential shifts in roles or operations.

The goal is for the parties to absorb the messiness of the initial collaboration, sparing members from having to navigate yet another complex system.

Develop processes for overcoming barriers

When working closely with members who are facing a wide range of health and social challenges, CBOs may encounter situations where standard communication procedures result in lengthy wait times for members. Escalation pathways[xvii] catalyze problem-solving by allowing CBO staff to contact a designated health plan representative who can assist with expediting solutions, including speeding-up or waiving prior authorizations, creating new workflows, updating stringent policies that inhibit collaboration, and running new forms of analysis and evaluation.

Escalation pathways should be formalized early in the relationship, and safeguards should be implemented to account for staff turnover. A common pitfall occurs when teams have an unofficial "go-to" staff member who helps them escalate and resolve their issues. If that individual moves to a new role, it can be challenging to replicate this positive dynamic. Escalation pathways are an important feedback loop to the health plan, and over time can help to identify policies and practices that are creating barriers that the health plan may want to resolve.

Implementation and continuous improvement

The implementation and continuous improvement phase focuses on strategies to sustainably advance the social care partnership. During this stage, the team assesses current implementation processes and uses data to understand barriers and opportunities to improve program performance and advance the shared vision.

Methods for effective implementation and continuous improvement

The communications pathways developed in pre-launch can generate significant shared learning and opportunities for continuous improvement. For example, routine partnership meetings, escalation pathways and joint operating committee meetings can identify common barriers experienced by members. Payers can involve staff from different departments to review challenges and develop innovative solutions. For example, the parties may identify the disproportionate impact that a particular process (e.g., prior authorization), network gap or formulary issue has on certain populations (e.g., people experiencing homelessness), and work to develop alternate pathways or additional supports.

Establish methods to discuss and address member-related issues

Types of routine meetings to address member-related issues will vary depending on the partnership; however, all contracts should have designated meetings to work through member-specific conversations. These can take the form of case conferencing rounds focusing on member and care team challenges, reviewing member-level data or discussing each team's priorities for continuing to work with members. Successful meetings incorporate the following core components:

- Routine program operations
  - Meeting preparation: Prior to partnership meetings, the CBO/CCH can compile lists of active member clients (and their member ID numbers), unresolved member issues, members they are working to identify and engage and other relevant program or data information. Discussing members with unresolved issues should be a priority.
  - Staffing: Partnership meetings are great opportunities for the health plan's clinical leads to deepen their understanding of program details. The discussions allow relevant decision-makers to learn about active challenges experienced by members, which they can elevate for process improvements.

Establish and run a joint operating committee

Joint operating committee (JOC) meetings are regularly scheduled discussions among program stakeholders to share program updates, challenges and achievements. Routinizing JOC meetings builds and strengthens the partners' relationship at the same time maintaining forward momentum around program activities and achieving the shared vision. If leadership's presence has declined, the JOC is the key touchpoint that leaders should join when possible, to signal continued relevance and remind the teams of the larger vision for the work.

- Staffing and scheduling: As a best practice, the parties should meet monthly at a standing time with the necessary care team members, such as frontline staff, administrative and programmatic leads, medical leadership and executive sponsors. Additional staff can be invited as needed to confer around milestone tasks, like data-platform onboarding or reviewing ancillary data. It can be beneficial to hold the meeting even if attendance is occasionally low, to keep the momentum of the partnership.
- Agenda setting and communication: Teams can use JOC meetings to generate conversation about referral volume, engagement rates, sub-population trends and opportunities for continuous program improvement. Creating an expectation of active involvement from both sides helps ensure a collaborative tone that produces real-time problem-solving and joint program ownership, rather than the CBOs only presenting and defending metrics. Shared leadership responsibilities from the payer and CBO at JOC meetings underscores the collaborative nature and shared accountability of the partnership.
- Tracking data/results: Both parties are working toward a level of volume that produces meaningful impact on population outcomes and metrics. It is important that JOC meetings include mutual data sharing and review to track programmatic results and co-design solutions as needed.
- Maintaining follow-up: Once a meeting is complete, a staff member should be designated to send final slides and notes to the core team and other stakeholders who were not in attendance. Prompt and standard follow-up will help maintain open communication, keep the project relevant to the project teams' daily operations, as well as socialize the partnership more broadly across the organizations.

To learn more about how to run a JOC meeting, consult the *Joint Operating Committee Template* slide deck.[xviii]

Deepening the partnership to drive future work:

As the partners work and learn together, they can look for opportunities to share learning, and change policy and practice together, including:

- *Disseminating information and promoting the partnership:* The payer and CCH/CBO can collaborate to highlight improvements made through the partnership in ways that are authentic and respectful of members, such as blogs, briefs and regional or national conference presentations.
- *Uplifting member experiences:* Because CBOs have strong connections with the members they serve, they can connect plans with members who are open to sharing their experiences. The CBOs can identify opportunities for members to share their stories, obtain consent and provide a warm hand-off to a plan's community engagement or communications teams.
- *Utilizing data for future programs:* Once programmatic data has been collected and evaluated, the CBO and health plan should collaborate on using the information to drive future programs addressing needs or populations identified through the current program.
- *Advocating for policy reform:* The experience of working together will often highlight opportunities for policy change that could help grow the partnership or otherwise improve the lives of those served. They can also provide important examples of success to illustrate the need for policy change. By speaking with one voice, payers and CBOs can have greater credibility and influence with policy changemakers than either one can acting alone.

Contract renewal and expansion

Contract renewal discussions will ideally begin months before the end of the contract term. These discussions allow both parties to reflect on program data and impact; what is working well and opportunities to expand the partnership. Conversations about what elements to adjust, scale or sunset should occur across all team representatives. The teams may decide they need more time to comprehensively assess the work and may choose to extend the timeline of the existing contract while developing the next iteration of the partnership.

If the teams decide not to move forward with a contract renewal, the parties should work together to ensure members and other partners are aware of the timeline for concluding the work. If members are actively engaged in programming, frontline staff should be provided with standard messages and training to communicate with members about the end or transition of services.

Regardless of the next steps, this final stretch of the contract should offer the partners the chance to celebrate their shared accomplishments and discuss how to promote lessons learned to relevant stakeholders. This will advance knowledge among the health and social care sectors on how payers and CBOs can partner effectively, with the goal of improving the health, wellness and well-being of members.

Conclusion

Addressing HRSNs is key to improving population health. The US health care landscape is rapidly shifting to prioritize the integration of health and social needs, driving payers, CCHs and community-based organizations quickly learn how to navigate new processes, procedures and cultures to work together. Health care–CBO/CCH partnerships are more likely to succeed when they are grounded in shared leadership and collaboration that leverages each partners' unique strengths. Focused attention on mutual understanding, open communication and collective problem-solving at each stage of the relationship—from preliminary exploration and vision setting through renewal and expansion of contracts—can help ensure the success of these critical cross-sector partnerships.

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 the Camden Coalition, which served as author. 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[xix] (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 To learn more about the value of social care partnerships, review ***Partnerships with Community-based Organizations: Opportunities to Create Value***. The resource presents five overarching reasons why health plans should partner with CBOs/CCHs to address social needs.

ii **https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10449-w**

iii **https://prodadbi.wpenginepowered.com/wp-content/uploads/2022/03/2022-Advancing-Partnerships.pdf**

iv 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 broad geography and provides a wide range of services. The CCH provides centralized administrative functions and contracts on behalf of community care network members.

v Strategies for aligning around billing structures are not included in this brief. *A Health Plan's Guide to Paying CBOs for Social Care* provides guidance on special billing and payment considerations for CBOs when standard processes are not suitable.

vi ***Partnerships with Community-based organizations: Opportunities to Create Value*** provides case study examples of when payer-CBO/CCH partnerships work towards a common goal and vision.

vii The individuals being served by the CBO will be referred to as "members" throughout the resource.

viii **https://hbr.org/2013/05/what-is-organizational-culture**

ix **https://www.researchgate.net/publication/324687637_A_HYPOTHETICAL_APPRAISAL_OF_CORPORATE_CULTURE_AND_ORGANISATIONAL#pf3**

x Partners can draw upon organizational culture models from business sectors, such as **Michelle Gelfand's model describing Tight and Loose frameworks** and **Scholes and Johnson Cultural Web**, to identify key unspoken expectations and misalignments in "how things should be done."

xi A human-centered design process is a problem-solving strategy that prioritizes the needs of the individuals impacted by the issue. There are four essential phases of the design process: Clarify, ideate, develop, and implement. More information about human-centered design processes can be found here: **https://online.hbs.edu/blog/post/what-is-human-centered-design**.

xii *A Health Plans' Guide to Paying CBOs for Social Care* provides case study examples of how health plans were able to adapt their standard vendor processes for billing and payment when contracting with CCH/CBOs.

xiii **https://www.aginganddisabilitybusinessinstitute.org/developing-cbo-contract-scopes-of-work/**

xiv **https://www.aginganddisabilitybusinessinstitute.org/a-health-plans-guide-to-paying-cbos-for-social-care/**

xv ***Partnerships with Community-based organizations: Opportunities to Create Value*** and *A Health Plans' Guide to Paying CBOs for Social Care* highlight case studies demonstrating the value of contracting through CCHs to consolidate administrative, payment and communication functions.

xvi To learn more about where CCHs are located in the US, consult **the Administration for Community Living map** or email **communitycarehubs@acl.hhs.gov**.

xvii Escalation pathways represent a process for elevating challenges and disagreements to higher level authorities within the health plan or CBO for prompt attention. Effective escalation pathways ensure efficient problem-solving and decision-making.

xviii **https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2023/11/JOC-Template_08.23.2023-1.pdf**

xix 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**.

Template: Joint operating committee meetings

A companion piece to *Operationalizing contracts: Methods payers can employ to collaborate with community-based organizations*

Participants

Joint operating committee (JOC) meetings are an opportunity to convene interdisciplinary stakeholders.

As payer and CBO staff are planning JOC meetings, they should think about including individuals who can thoughtfully contribute to conversations and decisions around agenda items. This may look slightly different for each meeting.

Core team participant list

- Administrative leads
- Programmatic leads

Additional participants as needed

- Frontline staff
- Medical leadership
- Executive sponsors
- Community care hub (CCH) staff
- Technology and compliance staff
- Data and analytics

Agenda

JOC meetings provide time for project collaboration about volume, engagement rates, sub-population rates, and continuous improvements. An agenda may include the following information:

- Member story
- Data presentation
- Process improvements and program updates
- Organizational updates

Member story

The goal of the member story is to humanize the work and demonstrate the program's impact on the ground. This story is often presented by the frontline staff member(s) who work closest with the individual; however, this story can also be told by the CBO staff or jointly with the health plan staff. Presenters may want to select a member story of someone who has overcome significant challenges or is facing a challenge due to a programmatic constraint to draw attention to opportunities or areas of improvement.

When sharing a member story, staff should keep the following points in mind:

- Receive consent from the member to share their story at the gathering.
- Keep the member's identity anonymous.
- Use person-first, strengths-based language to describe the member and current situation.
- Take this as an opportunity to demonstrate the member's role in the community and the relationship they have cultivated with their care team.
- Anchor the story in how the program helped facilitate health improvements for the member.

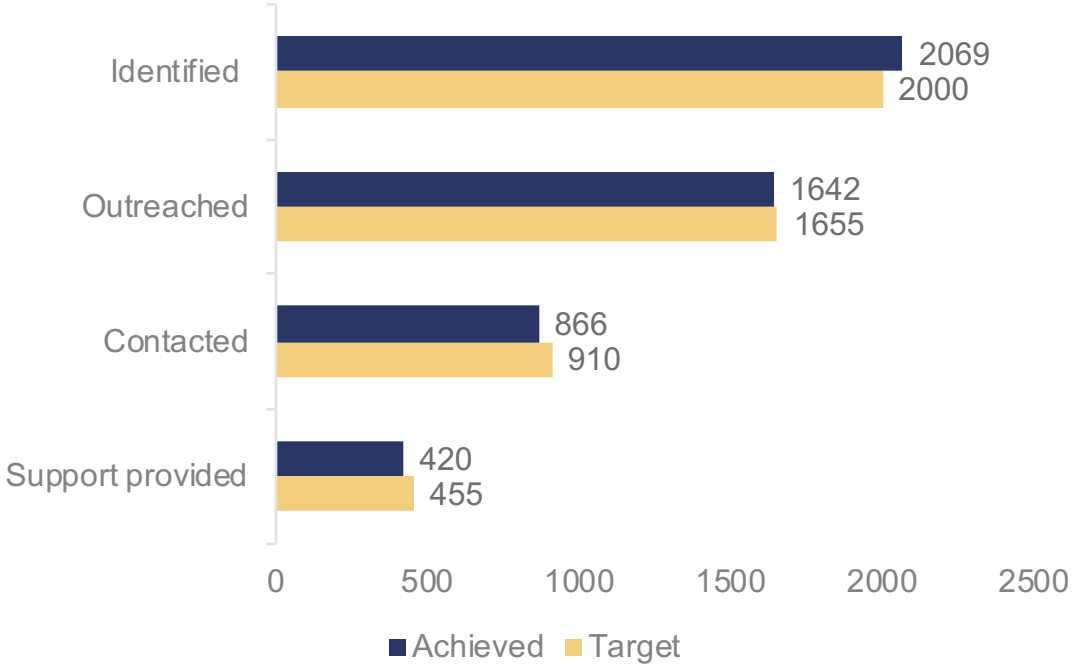
Data presentation

During the JOC meeting, review and discuss programmatic data that measures progress and highlights successes and challenges of the work. Both the health plan and CBO should be prepared to share out relevant data. The information can be useful for answering questions related to critical aspects of the program, including engagement, eligibility, and other programmatic components. The data presented at these meetings may shift over time and should be used to generate conversation about continuous improvement.

Some important points to consider when sharing data:

- Align on standard methods of showcasing data. Data visualization is important for informing executive level attendees about program metrics and future projections.
- The data domains discussed each month can change based on trends.
- Make sure the data demonstrates trends and progress related to the program targets.
- Ensure that individuals presenting data explain the information using language that is accessible to all people attending the meeting.
- Be mindful of the burden that additional data requests have on the CBO.

Data presentation: Sample score card



- **Outreach goal was 80%**
  - **Outreach rate was 79%:** Out of **2,069** patients assigned, **1,642** were outreached.
- **Contact goal was 55%**
  - **Contact rate was 53%:** Out of **1,642** patients outreached, **866** were successfully contacted.
- **Support-provided goal was 50%**
  - **Our support-provided rate was 48%:** Out of **866** successfully contacted patients, **420** accepted support.

Process improvements and program updates

Discuss next steps for process improvements and program updates. Topic areas can include:

Member engagement
- Who is identifying and assigning members?
- How are members being engaged in services?
- What are areas of improvement for member communication processes?
- What are areas of improvement or methods for driving higher engagement?
- How can program marketing to members be adapted or improved?

Workflow enhancements
- Where are there bottlenecks in workflows between the CBO and health plan staff?
- What areas of the escalation pathway should be made more effective?

Status updates
- What progress has been made on the program or member concerns discussed in previous meetings?

Emerging opportunities
- What are unexpected outcomes of the program that can be turned into future work?

Organizational updates

JOC meetings are opportunities to think about the current and future work of each organization involved in the partnership. When setting the agenda, close by sharing updates on the CBO and payer's organizational work.

Leaving time to discuss the CBO and payer's current and future work can create space for problem-solving and thought-partnership that extends beyond the contracted program and improves other areas of work.