At the Nexus of Social Care: Successful Contracting Between CBOs and Health Care Entities

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Background

The need for effective person-centered integrated systems of health and social care has driven a number of innovations that strategically link health care, long-term services and supports, and home- and community-based services. *Social care* is a term that acknowledges a fundamental principle of such innovations: the health-related value of screening, assessment, and services that address social risks such as food insecurity, housing instability, and social isolation. A growing body of research has shown positive health outcomes that can result from addressing these social needs and risks related to social determinants of health (SDOH), including reduced low-need nursing home use and lower rates of avoidable hospitalization. Awareness of the importance of addressing health-related social needs (HRSN) has risen to the level of a U.S. Department of Health and Human Services (HHS) Call to Action and a U.S. Playbook to Address Social Determinants of Health.[1, 2]

Models for achieving effective integration of social care and health care are evolving. Contracting between community-based organizations (CBOs) and health care entities is an increasingly common approach. In these arrangements, health care partners, such as hospital or health systems, accountable care organizations, and managed care organizations contract with CBOs such as Area Agencies on Aging (AAAs), Centers for Independent Living (CILs), and Community Care Hubs (community-focused organizations that organize and support community organizations providing services to address health-related social needs through centralized administrative functions and operational infrastructure).

There is consensus and evidence that screening for, assessing, and addressing social risks can improve health outcomes and reduce avoidable health care utilization. To design systems that are most likely to produce these outcomes, it is important to identify the specific pathways through which these goals are achieved. In making the case for a refined logic model that clarifies the intermediary steps along these pathways, Gottlieb et al. call for a refined logic model to better understand the ways in which social care can influence health outcomes; they suggest that the refined model should clarify specific mechanisms and the related outcomes.[3] For example, a CBO care manager can connect people to nutrition services that might reduce risk for food insecurity, thus reducing risk for negative health outcomes related to poor nutrition. Similarly, the transportation services provided by a CBO might improve a client's utilization of necessary outpatient health services, potentially reducing the likelihood of avoidable emergency department utilization. The CBO care manager might also improve the client's sense of emotional support, which can have a beneficial effect on their health. Understanding the multiple ways that CBOs contribute to these mechanisms can clarify and strengthen their role in contracts with health care partners.

Such information can also be useful to the health care partners. Currently, a lack of information about costs, benefits, and implementation of social care integration strategies can be a barrier for health care providers and payers to move in this direction. One recent article suggested that health systems are frequently making ad hoc decisions on how they will incorporate new research and strategies into care delivery.[4]

With funding from The John A. Hartford Foundation, the Administration for Community Living (ACL), and The SCAN Foundation, the Aging and Disability Business Institute (Business Institute), led by USAging, supports the business acumen of CBOs to enhance contracting with health care partners. The Business Institute began its work in 2016; those efforts have been documented and assessed by Scripps Gerontology Center at Miami University, the independent evaluator for the project. A key component of the evaluation is a CBO-Health Care Contracting Survey that has been conducted in 2017, 2018, 2020, 2021, and 2023.[5,6,7,8] The survey was developed and disseminated in collaboration with the Business Institute and its partners. The goal of these surveys has been to measure the extent to which CBOs are contracting with health care entities individually and as part of a network; to document the services, target populations, infrastructure, and payment models of these contracts; and to understand the challenges, benefits, and elements of success related to these contracts.

This report summarizes data from the 2023 survey of CBOs and networks of CBOs about their contracting relationships and activities with health care partners. The 2023 quantitative findings are contextualized with data from earlier surveys, and with insights from a qualitative study of eight networks of contracting CBOs. The data support efforts to understand and articulate the value of CBO-HC contracts as a model for aligning health and social care.

Key Findings

Since the inception of the Business Institute, the proportion of CBOs contracting with health care has increased significantly, from 38% in 2017 to 47% in 2023. The proportion that are not contracting and not pursuing contracts decreased significantly during that same time period, from 45% to 37%. Some key features of these current contracting relationships suggest that the viability, maturity, and strength of this model of social care are growing:

- The percentage that are contracting as part of a network has grown from 20% in 2017 to 36% in 2023.
- The majority of contracting CBOs (85%) are receiving revenue for at least some of their contracts, and 80% are receiving revenue for all of their contracts.
- Risk-based payment models are becoming more common for contracting CBOs, and reliance on fee-for-service has decreased.
- Contracting CBOs are increasingly involved in provision of services for person-centered planning, transitions from hospital to home, and caregiver support and training.
- CBOs are serving vulnerable and high-risk populations through their contracts, including individuals at risk for nursing home placement, emergency room use, and hospital readmission; people who are dually eligible for Medicare and Medicaid; and individuals who are homeless or at risk of becoming unsheltered; and individuals who are immigrants or non-native English speakers.
- Nearly half (48%) of contracting CBOs said that contracting better positioned them as valuable health care partners; 43% said that contracting relationships have expanded their visibility in their community.

METHODS, RESPONSE RATE AND DATA SOURCES

The fifth CBO-Health Care Contracting Survey was launched in October 2023 and remained in the field for nine weeks, closing in December 2023. The online survey was disseminated by email to the population of 614 AAAs, 403 CILs, and another 173 CBOs that had completed a survey in the past. In addition to the emailed surveys, Business Institute partners promoted the survey through email, newsletters, and social media to reach additional CBO organizations. A total of 514 surveys were received. AAAs represented 58% of survey respondents in 2023 with CILs representing 25% and other CBOs, 18%.

Table 1. Response Rate by Organization Type, Across Waves

	2017	2018	2020*	2021	**2023**
	N (response rate)				
Area Agencies on Aging	351 (56%)	409 (66%)	184 (30%)	332 (54%)	**296 (48%)**
Centers for Independent Living	119 (38%)	174 (28%)	95 (24%)	130 (30%)	**128 (32%)**
Other CBOs**	106	143	166	110	**90**
Total	576	726	455	572	**514**

*The 2020 survey was launched in March of 2020, just as the COVID-19 pandemic was taking hold, which may explain the slightly lower response rate.
**CBOs include a broad range of organization types across the nation such as United Way, Easterseals, and faith-based organizations for which the true denominator is unknown, unlike AAAs or CILs.

RESULTS

Trends in Contracting Status, Partnerships, Networks and Community Care Hubs

Contracting Status

Since 2017, respondents have been asked whether they are, at the time of the survey, contracting with health care entities. If a CBO is not contracting, they can indicate whether they are in the process of contracting or are not pursuing any contracts. The exact wording of the definition used for contra contracts and the question asked in the 2023 survey can be seen in the box below.

Contract Definition and Question:

A **contract** is defined as a legally binding or otherwise valid agreement between two or more entities with the intent to exchange payment for services or programs. Contracts may be established directly between the CBO and health care entity, or through a network of CBOs with a health care entity.

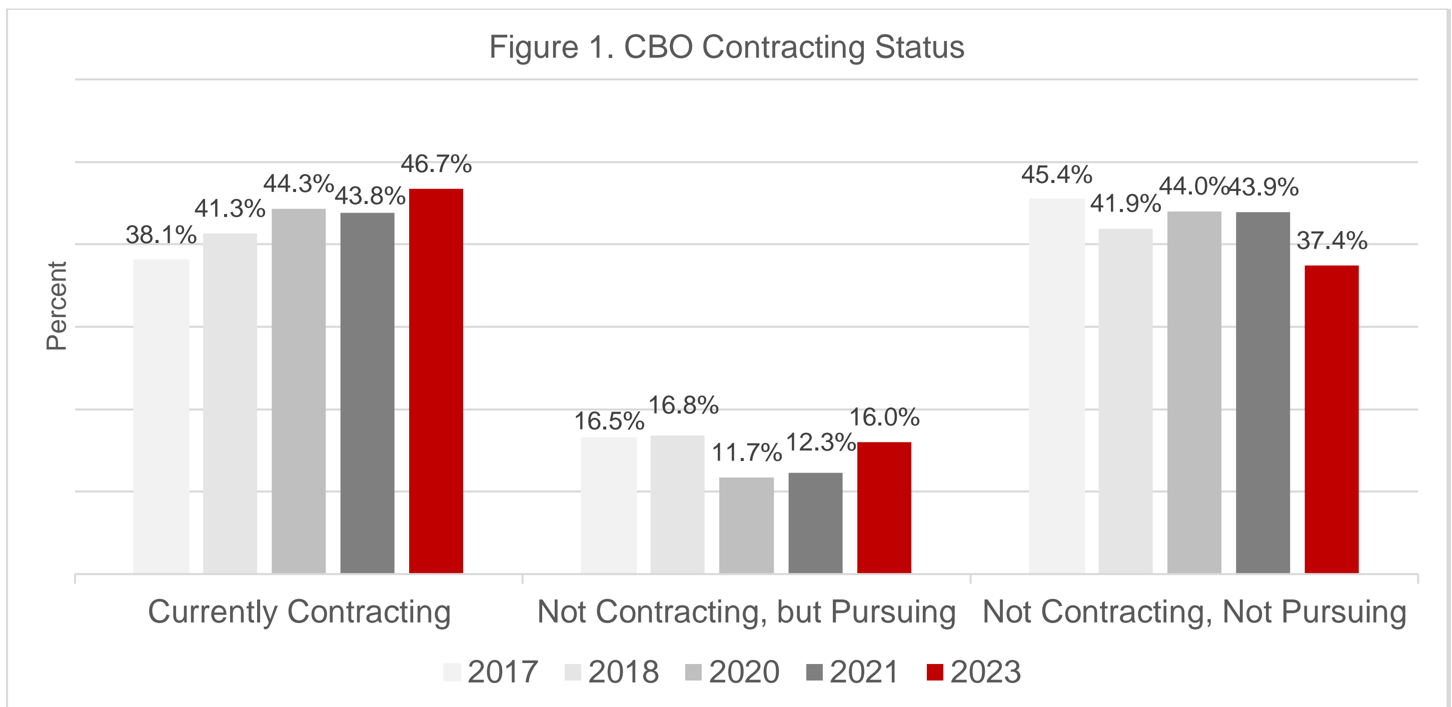
For the purposes of this survey, we are interested in contracts in which your CBO or network receives (or will receive) payment from a health care entity.

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

Response options were:

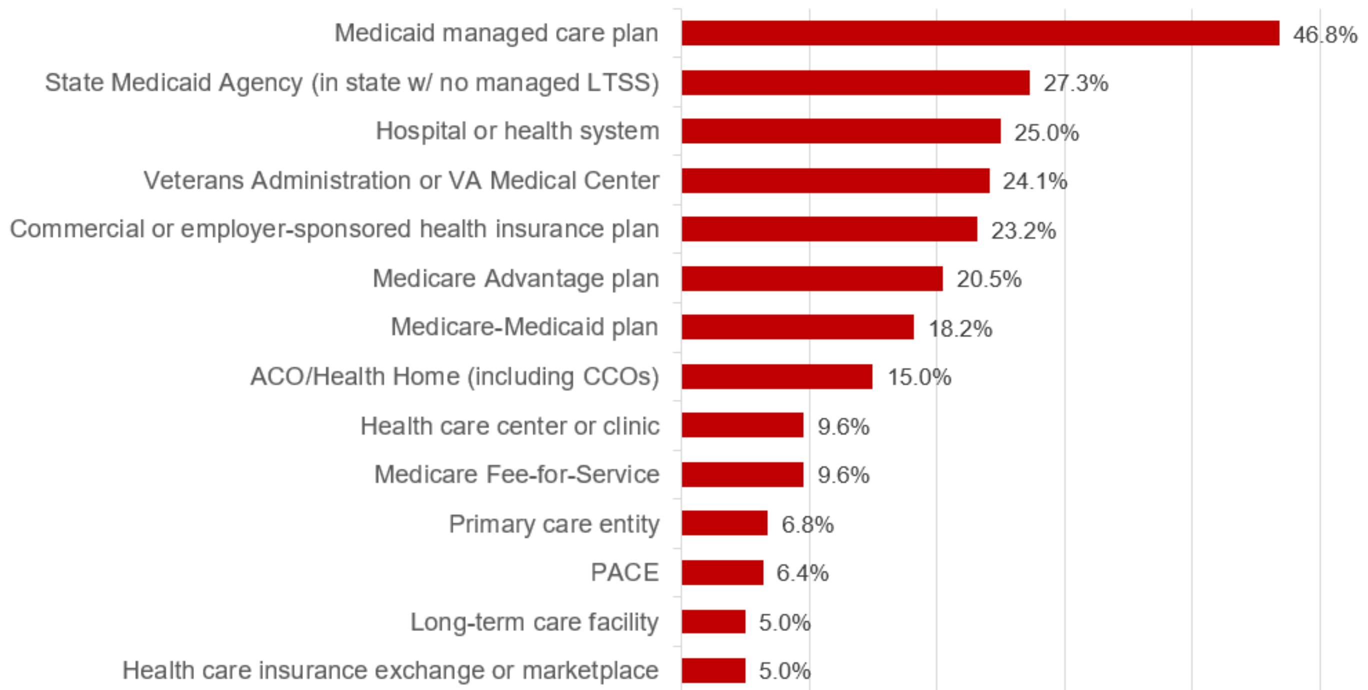
YES,	NO,	NO,
we currently participate in contracts with health care entities	BUT we are in the process of pursuing a contract with a health care entity	we are not pursuing contracts with health care entities

The contracting question has been asked over all five surveys. The resulting trend data tracks the prevalence of contracting over the past 6 years. Figure 1 shows the proportion of CBOs contracting with health care entities since 2017. There has been a steady increase in the percentage of CBOs contracting over time, with nearly half (47%) of responding CBOs stating they have at least one contract, a statistically significant increase between 2021 and 2023. Similarly, a statistically significant decrease was found between 2021 and 2023 for CBOs that are not contracting and not pursuing, from 45% to 37%. On average, contracting CBOs have 3.9 contracts (median: 2); 85% have held their longest running contract for 3 or more years.



Partnerships

Figure 2 shows the proportion of contracting CBOs that work with specific health plans, payers, and providers. Medicaid managed care plans continue to be the most common partner for CBO contracting efforts, and that proportion increased significantly from 41% in 2021 to 47% in 2023. About a quarter of contracting CBOs partner with their state Medicaid agency (generally in states with no managed long-term services and supports). Other partners reported by about 25% of contracting CBOs are hospital or health systems and the Veterans Administration or Veterans Administration Medical Center. Because Medicare Advantage plans have emerged as an important new opportunity for contracting CBOs with the expansion of supplemental benefits under such plans, a closer look was taken to see how those numbers changed since the last survey in 2021. There was a statistically significant increase in the percentage of CBOs contracting with Medicare Advantage Plans, from 16% in 2021 to 21%in 2023.



Role of Networks and Community Care Hubs

Contracting through networks, rather than as a single-agency entity, has become an increasingly prevalent model. Networks are coordinated groups of CBOs that pursue a regional or statewide contract with a health care entity. Network-based contracting allows for more efficient and standardized negotiation, implementation, and management of contracts between CBOs and their health care partners, as well as shared infrastructure (e.g., information technology) to support contracting. Thirty-six percent of contracting CBOs indicated they entered into at least one of their contracts as part of a network. That is nearly double the 20% that reported contracting as part of a network on the first survey of CBOs.

The importance and value of the network model has led to concentrated efforts to grow and support the work of the entities that lead them: Community Care Hubs. A Community Care Hub (CCH) is a community-focused entity supporting a network of CBOs that is providing services addressing health-related social needs; the CCH centralizes administrative functions and operational infrastructure. A Community Care Hub is often referred to as a CCH or Hub; the term replaces the formerly used term of Network Lead Entity (NLE). The newly established Center of Excellence to Align Health and Social Care, funded by the Administration for Community Living and administered by USAging's Aging and Disability Business Institute, speaks to the increasing investments in the CCH model.

In total, 29 CCHs were identified from all survey respondents. Nine of the 29 CCHs were a stand-alone CCH. The remaining 20 were considered a CCH within or in conjunction with another type of organization. For example, an Area Agency on Aging may house or be considered the CCH in

addition to their role as an Area Agency on Aging. While 29 CCHs were identified, specifics about the networks were collected from only 28 CCHs. While this is a relatively small number, the depth of the data is valuable as networks and CCHs continue to evolve.

On average, these networks have been in operation for 8.8 years (median: 7) and hold an average of 5.9 contracts (median: 2). Networks include an average of 27 CBOs (median: 21); the most common types of CBOs in the network are AAAs (86%); “other” nonprofit organizations such as Easterseals, Red Cross, United Way (46%); supportive service providers (43%) and faith-based organizations (36%). Networks most commonly cover a statewide geographic area (61%) while 18% cover a region within a state and 11% are multi-state. More than half (54%) are a subsidiary or separate division under a larger agency such as a AAA or a CIL. One quarter are free-standing entities established specifically for the purpose of serving as a hub. Nearly half (46%) contract out some of their administrative functions to a network member or vendor.

What do CBOs, CCHs, and their Networks Bring to the Table?

CBOs are often backbone organizations in their communities, supporting and coordinating services for older adults and people with disabilities. AAAs, for example, have five decades of experience and expertise with assessing and addressing HRSNs for older adults, caregivers and, in many cases, people with disabilities to enable them to live independently in community settings. Their legislative mandate includes assuring comprehensive, coordinated, and streamlined access to services for older adults. CBO community-centeredness and areas of professional expertise position them well to contract with health care partners to effectively provide HRSN-informed assessments and services.

The following results from the 2023 survey highlight the ways in which health care entities contracting with CBOs can elevate and integrate HRSN-based assessments and services, reach underserved and at-risk populations, and support health care partners in achieving their health equity goals.

Health Equity

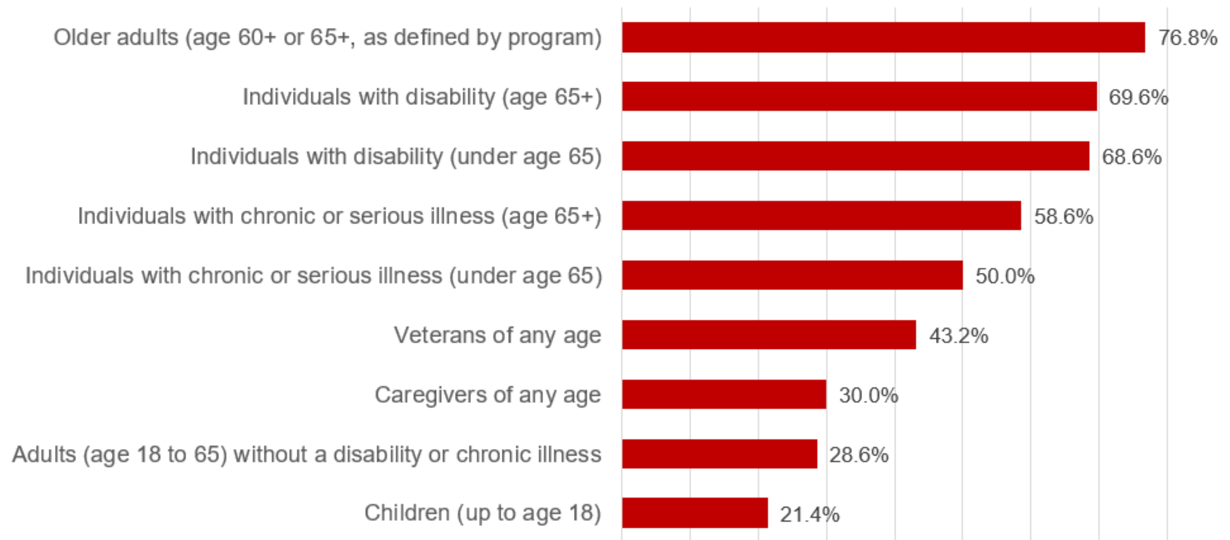
As illustrated in Table 2, the majority of contracting CBOs said that their ability to reach underserved groups played a role in their partnerships with health care entities. For about one-third of contracting CBOs, their potential contributions to health equity are part of the conversations with health care partners and are included in the value propositions they offer. One in eight contracting CBOs indicated that health equity goals or initiatives are written into their contracts with health care entities.

Table 2. Role of Health Equity in Contracting

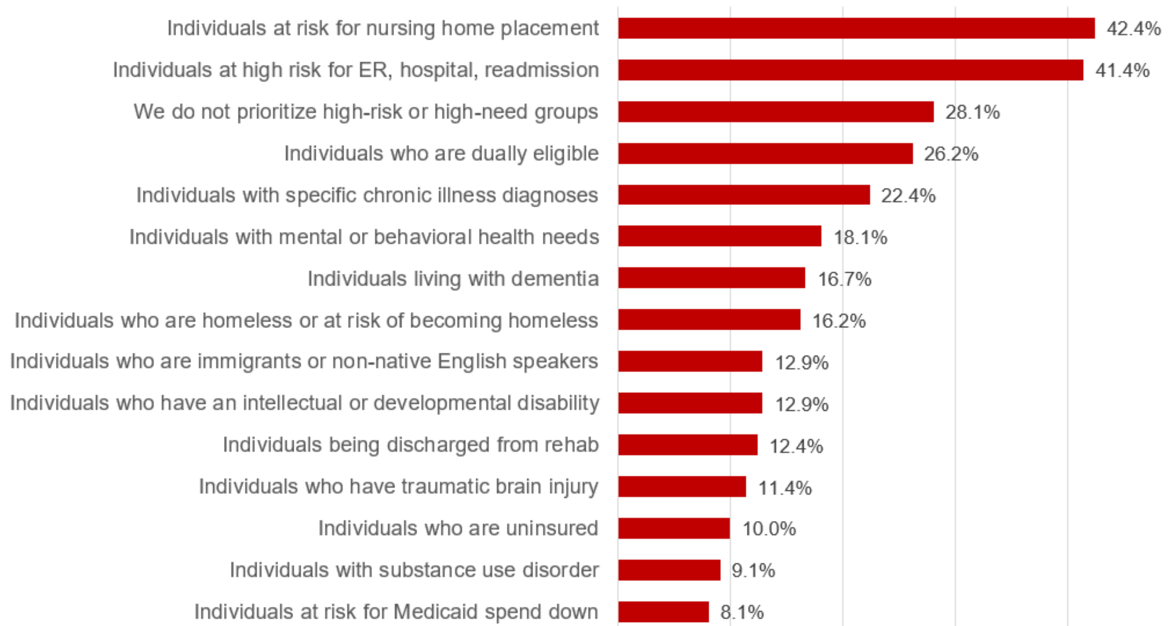
	Percent
Our ability to reach underserved populations is one of the reasons our health care partners contract with us	60.7%
Health equity has been part of our conversations with health care partners	34.3%
Health equity is part of the value proposition we provide to health care partners	29.6%
Health equity goals or initiatives are written into our contract	12.5%

Populations Served

Figure 3 shows the populations served under these contracts. In addition to their consistent focus on older adults, and on people with disabilities and/or serious illness, contracting CBOs have become more involved with caregivers of any age and veterans of any age. The proportion serving each of these two latter groups increased significantly between 2021 and 2023.

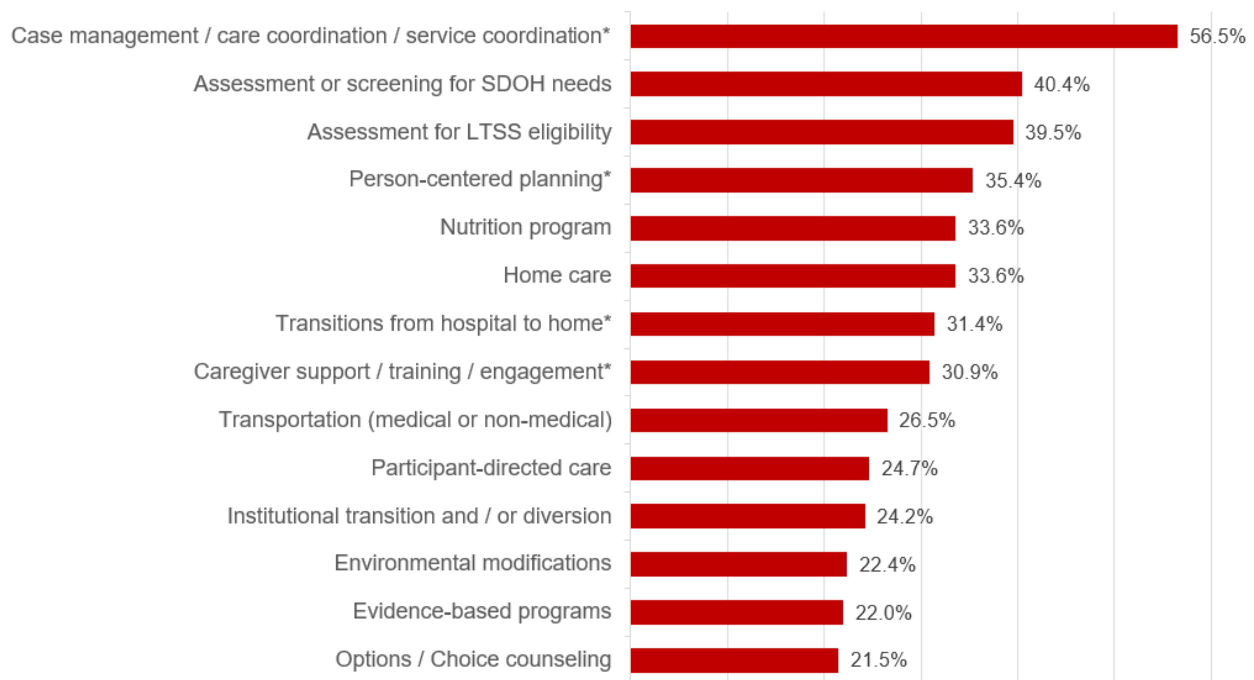


In addition to these populations, CBOs also focus on individuals with complex care needs. As seen in Figure 4, these contracting organizations are very involved in serving people at risk for nursing home placement, those at risk for emergency room visits or hospital readmission, and those who are dually eligible for Medicare and Medicaid.



Services Provided

Assessment for SDOH and long-term services and support needs, and coordination of person-centered service plans, are at the heart of what many CBOs do for members of their communities, and for those served through HC contracting. In addition, they provide specific direct services such as nutrition, transportation, and caregiver support. The coordination and access services, as well as specific interventions and supports provided by CBOs, directly reinforce the integration of HRSN with health care. Over time, the set of services provided by contracting CBOs conveys an increasingly unified message about their role in social care. The proportion that are providing caregiver support, care coordination and service management, person-centered planning, and transitions from hospital to home have increased significantly over the past two years. The primary services that CBOs provide through their contracts with health care partners are those that they are uniquely qualified and experienced to provide, as shown in Figure 5.



**Statistically significant increase between 2021 and 2023.*

Components of Success for Contracting CBOs

The national survey of CBOs included a series of questions about the ways in which contracting affected their organization in terms of position in community, internal operations, and revenue. There were also a series of questions about referrals and about data systems, sharing, access, and interoperability. These questions shed light on the benefits and challenges CBOs encounter when contracting with health care entities.

Better Positioning CBOs & Broadening Reach

While CBOs have continuously and successfully served their communities, contracting has allowed them to better position themselves as valuable partners with health care providers and systems (as noted by nearly 48% of CBOs). In addition, 43% have been able to expand their visibility in the community. Being viewed and valued as a partner within these settings creates stronger systems of integrated care among individuals being served.

In addition to building and strengthening partnerships within their communities, contracting has allowed CBOs to broaden their reach. CBOs are able to expand or enhance the types of services offered (34%), increase the number of people served(41%), expand the type of populations served (25%) and increase their geographical scope (11%).

Improved Internal Operations

Contracting has allowed CBOs to make positive changes to how their organizations operate through increasing organizational capacity and investing in infrastructure. Twenty-three percent of CBOs have been able to increase their staff size and 11% noted that the culture of their organization changed for the better as a result.

Taking on contracting often requires CBOs to evaluate whether they have the appropriate systems and processes in place to meet the demands of their partnerships. Nearly 14% have been able to increase their investments in their own infrastructure and technology needs, and over 15% of CBOs have increased their focus on continuous quality improvement through their health care contracting work.

These internal changes, combined with the ability to expand the services they provide and the areas they serve, make contracting an effective way to reach more individuals, increase capacity, and sustain programming.

Generating Revenue and Expanding Payment Models

Contracting CBOs reported that contracting increased their organizational net revenue (38%), enhanced their organization's or network's sustainability (35%), and allowed their organization to obtain funding from new sources (29%).

Nearly 85% of contracting CBOs are generating revenue through their contracts with health care entities and 80% of CBOs are receiving payment for all of their contracts. Of those not yet receiving payments, the most common reason for lack of payment is that they are not yet providing a service for which they can bill (56%), with another 20% noting issues with the payer’s internal process (referral or payment process). CBOs reported that, on average, 26% of their organization’s revenue comes from their contracts with health care entities, a statistically significant increase from 21% in 2021. Likewise, on average, 26% of the contracting CBOs’ organizational expenses are related to contracting efforts.

The most common payment model used in contracts with health care entities continues to be fee for service (FFS) with just over 70% of CBOs being paid in this manner. This number decreased from

78% in 2021, while alternative payment models such as case rate (25%), pay-for-performance or performance-based contract (15%), full-time equivalent based contract (11%), shared risk (4%) and shared savings/incentive payments (3%) increased significantly between 2021 and 2023.

When asked about measures used in any contracts that help determine their payments from health care entities, CBOs indicated payment is heavily tied to the number of clients served or service units provided (70%), followed by submission of data or reporting (46%), accuracy or completeness of documentation, claims or other records (46%) and timeliness output measures (36%).

Managing Data Interoperability: Receipt, Access, and Exchange

Data is a critical component of contracting for CBOs and health care entities alike. How data is received, accessed, and exchanged can impact the programs and services being provided (as well as the individuals receiving those services), and can influence infrastructure and operations for the CBO. Building, managing, and maintaining a robust data ecosystem is extremely important but not always easily accomplished, and there is no one-size-fits-all model. While CBOs make strides towards developing these systems (14% of contracting CBOs reported that contracting has allowed them to increase their investment in infrastructure and technology), this continues to be an area of growth for their organizations. As one respondent stated, “the sharing of data seems to be ever evolving and changes as our relationship with our funders changes.”

CBOs recognize the value of establishing formal data sharing agreements with their health care partners. Over 45% of CBOs have a Business Associate Agreement with at least one of their health care partners and 41% have a Memorandum of Understanding with at least one partner.

Receiving Referrals

Over eighty percent (84%) of contracting CBOs receive referrals for contract services directly from either a health plan or health care provider partner and roughly 20% of CBOs contracting through a network receive their referrals from their network hub. In addition, 13% receive referrals through a social care referral platform such as UniteUs/NowPow or FindHelp.

Regardless of whether or not they are contracting, 23% of CBOs receive referrals for services from social care referral platforms, an increase from 20% in 2021. While the use of social care referral platforms is growing, most CBOs (70%) use existing sources to fund the services provided to those being referred through the platforms, rather than being paid by the health care entity contracting with the platform for closed loop referrals.

While referral platforms are an increasingly common mechanism, there is some progress to be made to ensure that the referrals are appropriate. Table 3 shows the frequency at which CBOs receive quality referrals. Currently only 57% of CBOs report that they receive complete and accurate referrals most or all of the time, and less than half (47%) say that client needs are accurately identified most or all of the time. For 60% of CBOs, the referrals they receive through a social care referral platform are within the populations they serve all or most of the time; 73% reported that referred clients are within their geographic service area all or most of the time. Referral platforms and their health care and CBO partners will benefit from working together to ensure that the referral process is efficient and provides high quality referrals.

Table 3. Quality of Referrals					
	All of the time	Most of the time	Some of the time	Rarely	Never
	%	%	%	%	%
Client contact information that we receive is complete and accurate	10.0	47.3	30.0	11.8	0.9
Clients' service needs are correctly identified	9.9	36.9	36.9	15.3	0.9
The clients who are referred to us are within the populations we serve	16.4	44.6	33.6	5.5	0.0
The clients who are referred to us are within the geographic area we serve	26.6	46.8	23.9	2.8	0.0

Submitting, Reporting and Accessing Data

While some CBOs have developed their own data systems or have been able to modify existing systems within their organization, many rely on their health care partner systems to submit and access data. Over 57% of contracting CBOs *submit or report* data through a health care partner's system (dashboard or portal), with another 13% through a Health Information Exchange (HIE), Health Information Network (HIN) or Community Information Exchange (CIE), 13% through a network hub, and 7% through a social care referral platform. For some contracts (dependent on the types of programs and services being provided), CBOs are reporting data through a file sharing platform (16%) such as SharePoint, Dropbox, Google Drive, Box or through encrypted email exchange (35%).

The most common way CBOs *access* data is through a health care partner's system with 46% of CBOs reporting they use a partner's dashboard or portal system. This is a marked improvement from 2021 where only 26% stated they had access to their partner's systems. In addition, 21% of CBOs receive routine data reports from their health care partners while 17% access data through an HIE, HIN or CIE and 11% through a social care referral platform. Over a quarter (29%) of CBOs indicated that they enter data into multiple systems so they can have access to the data.

Paths Forward

Contracts between CBOs and health care partners result from strategic decisions made by each partner targeted to improve the health of those they serve, and those decisions are based on a number of factors. The 2023 survey data shed light on facets of contracting that are important to the success and sustainability of the model for CBOs. A 2022 qualitative study designed to better understand how CBO networks form, operate, struggle, and succeed provides further context for the quantitative findings.[9] The qualitative study took place between August and October 2022 and included a total of 23 interviews with participants representing eight CBO networks across the country. Taken together, these data sources provide insights into factors that can maximize the effectiveness of contracting and increase the viability and sustainability of this vital model for social care. The insights provided by CBOs in the quantitative and qualitative studies underscore the following components of success for establishing, maintaining, and improving contracting relationships:

1. There were consistent messages from both the survey and qualitative study findings around the importance of the **data ecosystem** and the need for continued improvement in how health care and CBOs exchange data and share care. There is consensus that the flow of data among CBOs (as providers and coordinators of services), CCHs, and health care partners is essential for effective contracting; data flows are at the heart of referrals, reporting, reimbursement, performance management, and quality improvement. However, there is a lot of variability in how those data flows are accomplished, and in equity of access to data. The most seamless systems ensure access for all partners (within HIPAA requirements, and with data use agreements in place), typically with a single shared platform and appropriate infrastructure at all levels. More typical is a system that is pieced together, with variable access to data and different practices for submitting and accessing data. For example, some CBOs send email encrypted files to the health care partner, and some enter their data twice so that they can have access to what they are sending to the partner.

2. **Referral volume, quality, and predictability** was another driver of contract success that emerged from both sources of data. The ability of a CBO to manage contracts and accept financial risk is enhanced if there is predictable volume and quality of referrals.

3. As discussed above, the majority of CBOs are receiving **revenue** from their contracts. On average, the percentage of a contracting CBO's revenue that comes from contracts is equal to their expenses related to contracting (26%). However, there is variability within and across CBOs in terms of the revenue impact of any particular contract. Across all contracts held by CBOs, 45% are budget neutral, 46% are generating a profit, and 26% are running a deficit.

4. **Cost-benefit analyses** are essential to informed decisions about entering into contracting opportunities; these analyses need to include start-up costs for CBOs, and the possibility of investments from government and the health care partner in those infrastructure costs.

5. Shared understanding of each partner's **performance expectations** and measures of success increases the likelihood that a contracting relationship can be successful. Many CBOs discussed transparency, open communication, and commitment to the partnership as necessary elements of a viable and beneficial contracting arrangement.

A shared commitment to this mode of social care, the strength of existing and evolving relationships among CBOs, CCHs, and health care partners, and an explicit and shared dedication to meeting health-related social needs provides the necessary foundation for the continued growth, sustainability, and effectiveness of CBO-health care contracting.

Acknowledgments

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Endnotes

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