Institute for Accountable Care

Establishing Sustainable Partnerships with Community Based Organizations: Considerations for ACOs

Introduction

Accountable Care Organizations (ACOs) and their associated health care systems face growing expectations to advance health equity and address social drivers of health that contribute to disparities in outcomes. These efforts have led to increased interest in partnerships with community-based organizations (CBOs) that are uniquely qualified to provide services to address patients' social needs.

This Issue Brief focuses on how ACOs can build sustainable partnership with CBOs. Of particular importance for ACOs is attention to the financial sustainability of their community partners because many CBOs cannot meet the growth in demand for social service referrals without expanding their own capacity. CBOs will need a viable and sustainable financial model to expand their services that includes diversified sources of revenue including service contracts. This Issue Brief focuses on five considerations for ACOs interested in partnering with CBOs to address their patients' social needs.

1. The value of partnering with CBOs
2. Understanding the strengths and limitations of CBO partners
3. Limiting the administrative burden on CBO partners
4. Facilitating revenue opportunities for CBO partners
5. Seeking out CBO networks and community resource hubs

Prepared in conjunction with a Learning Collaborative on Addressing the Social Determinants of Health convened by the Institute for Accountable Care (IAC) and the National Association of Accountable Care Organizations (NACCOS), this document highlights key themes from the Learning Collaborative's discussions and links to relevant resources.

The Value of Partnering with CBOs

Health care institutions and providers are in the business of delivering medical care. Some like safety net hospitals and community health centers have long traditions of working with social service providers in their communities. But most health systems have only recently begun to think more systematically about addressing social drivers of health, and most lack the expertise and relationships to do it on their own. Doing this well takes time and requires dedicated resources. To effectively integrate social care with medical care, health systems must collaborate effectively and respectfully with community-based organizations.

CBOs have been working in their communities for decades and have in-depth knowledge of local institutions, leaders, resources, and community needs. The CBOs have developed trusted

relationships with the residents of diverse communities where some are skeptical that the medical system understands or values them. Many CBOs have expertise in screening for social drivers of health with cultural competence to ensure that individuals feel comfortable sharing sensitive information.

A growing number of CBOs have contracts with health care entities and are offering services such as assessments for social drivers of health, case management, nutrition interventions, care transitions, and other evidence-based programs. Additionally, many CBOs are adept at braiding a variety of public and private funding sources to address an individual's health-related social needs

CBOs are diverse and range from highly sophisticated service providers with strong administrative capabilities to support contracting, billing, and data exchange to small charities with dedicated, but limited staff and resources. Health systems will have difficulty working effectively with CBOs if they treat them as just another vendor. To build strong partnerships they need to invest in relationships and acknowledge the value of the services CBOs provide. This community and relationship building work is not something that health systems can assign to staff as a side project. It requires dedicated staff to manage CBO relationships and the complex job of coordinating with their own clinical and administrative stakeholders

Understand the Strengths and Limitations of CBO Partners

Effective partnerships between ACOs and CBOs depend on shared goals and a realistic understanding of each partners' respective capabilities and limitations.

- **It is important to understand CBO capacity and service offerings.** CBOs typically rely on a patchwork of funding sources to support operations and often depend on public support, grants, and charitable donations to fund operations. CBOs generally do not charge patients for services. They rarely have excess capacity available to accommodate large increases in demand but may be able to scale service offerings when given a reasonable timeline. Scaling operations to meet increased demand may require new funding, ideally in the form of contractually guaranteed payments that reimburse CBOs for the cost of services rendered.
- **CBOs may not use the same data systems or be required to abide by the same data privacy requirements as health systems.** Partnerships with ACOs may require CBOs to build new competencies and adapt their existing workflows to meet the requirements of health system partners. For example, CBOs may need to utilize new closed-loop referral platforms, complete privacy training, track and report new data, and adapt billing processes. When possible, health systems should try to align with CBO systems of record, referral workflows, and data and reporting processes.

Limit Unnecessary Administrative Burdens for CBO Partners

Administrative burdens may limit the ability of some CBOs to participate fully and effectively in partnerships with ACOs. Limiting administrative burdens should be an important consideration for ACOs.

- **Right-size reporting requirements.** ACOs should carefully consider the types of data reporting they require from their CBO partners, as well as the manner and frequency of data reports. Only ask for data that is a "must have" not "nice to have" information.
- **Agree on the desired outcomes of partnerships and on performance monitoring methods.** Before launching any new programs ACOs and CBOs should jointly agree on the desired outcomes and reporting criteria. Both parties should be mindful that small, pilot programs are unlikely to yield results detectable at the population-level and may need to rely on process measures until programs research sufficient scale for a more comprehensive evaluation.
- **Mutually determine the best mechanism for referrals.** If CBOs already have a referral process, the ACO should at explore using this process. If the existing process will not work ACOs should recognize the limitations of referral platforms and the challenges they may pose for some CBOs. While electronic referral platforms can facilitate "closed loop" communications, use of these platforms may come at a cost for both ACOs and CBOs even when access to the platform is free of charge. Ideally, platform selection should be made in consultation with CBO partners to avoid duplication and promote integration with existing workflows and information systems. Partners should be mindful that platforms may not facilitate all types of information exchange needed to support the partnership (e.g., sharing of outcome data, billing).
- **Contractual agreements can provide clarity on roles, responsibilities, and goals without being overly complex and legalistic.** ACOs and payers should be flexible about contracting mechanisms, and not burden CBOs with long, complex legal agreements. Standard contract templates developed for traditional vendor relationships may not be appropriate for partnerships with CBOs. Clearly explaining what the ACO hopes to accomplish with the legal documents and accepting questions and feedback from CBOs can help facilitate a smoother contracting process. Designating a single point of contact for CBO partners can also help with contracting and relationship building.

Facilitate Revenue Opportunities for CBO Partners

Third-party reimbursement will help CBOs scale their activities to support growing demand from health systems. While health plan reimbursement for social services remains limited, partnerships with ACOs have the potential to open doors to new revenue streams. Funding opportunities vary by type of social service and payer, but new flexibility to fund social care interventions through Medicaid, Medicare, and commercial plans has emerged in recent years.

For example VAAACares is an organization that operates a statewide program to reduce hospital readmissions in partnership with four health systems and three Medicaid managed care plans. VAAACares provides dedicated coaches to support in-home assessments and linkages to social services for recently discharged hospital patients including direct referral assistance, case management, benefits counseling, family caregiver support, and other non-clinical services such

as meals and transportation. VAAACares expansion was initially funded through its participation in the Centers for Medicare & Medicaid Services (CMS) Community Care Transition Program (CCTP). As the CCTP ended, VAAACares was able to obtain reimbursement for its services from Medicaid health plans. It currently also receives ACO and health system funding for specific projects and services.

- **Help CBOs make the business case for social services.** ACOs have the data needed to document patients' health care outcomes (e.g., readmission rates, ED visits, cost of care, care gaps). CBO partners have access to data related to the intensity, duration, and cost of social care provided to clients, as well as the social outcomes achieved (e.g., food security, stable housing). Partners can work collaboratively to bring these data together for a holistic understanding of the return on investment (ROI) for social service interventions. Demonstrating a positive ROI can be helpful in securing funding for social care from many organizations, however, it may not be essential to securing contracts to the extent that ACOs and health plans value non-financial considerations, such as improved patient experience and plan member retention.
- **Facilitate CBOs' relationships with health plans.** In addition to providing data and technical assistance, ACOs can help CBOs initiate relationships and even establish contracts with health plans. Health systems and ACOs have well established relationships with payers and can bring CBO partners into meetings to propose collaborative SDOH strategies. Health systems may also consider bringing CBOs into their own clinically integrated networks (CINs) and negotiating reimbursement for health-related social services on CBO's behalf.
- **Consider funding CBOs directly to finance non-medical services.** While direct funding from ACOs to CBOs to support social service interventions does not appear to be widespread, some ACOs have begun to contract with CBOs for non-medical services.
- **Grants from hospital community benefit programs can supplement funding for CBOs.** ACOs can help facilitate grants from their affiliated hospitals to support CBO efforts. Federal and state laws require not for profit hospitals to provide community benefits to justify their tax-exempt status. Hospitals have a great deal of latitude in defining the nature of these investments and some have made sizeable investments to address social drivers of health. These community benefit obligations may represent an untapped opportunity to access additional funding to address health-related social needs.

Seek Out CBO Networks and Community Resource Hubs

Some communities have established CBO networks that can provide broader access to services and enhanced coordination. CBOs, such as Area Agencies on Aging, have a long history of working together collaboratively to address a range of different clients' social needs. There are new efforts by CBOs to establish formal networks to facilitate contracting with health care entities, such as managed care plans, health systems, and health care providers. A 2020 study conducted by the Scripps Gerontology Center found that approximately 40 percent of CBOs that contract with health care entities do so as part of a formal network.

A growing body of evidence suggests that efforts to improve medical outcomes and lower costs by addressing social drivers of health will be more effective if CBOs, health plans, and health systems develop formalized partnerships within collaborative networks. Working with formal CBO networks benefits both ACOs and participating CBOs. These networks often provide a broad array of services in larger geographic regions. Participating CBOs may also benefit from economies of scale for marketing, billing, and other administrative activities and may strengthen their position in pricing and contract negotiations.

For example, VAAACares is a consortium of Virginia's 25 Area Agencies on Aging and serves as a statewide collaborative that performs hospital-to-home interventions, care coordination, and other social services. In 2021 VAAACares was awarded a two-year grant from the Administration for Community Living to act as the Community Care Hub (formerly known as a Network Lead Entity) for a statewide CBO Network. These grants, awarded to 12 organizations, seek to accelerate and optimize efforts to develop effective community networks.

Conclusion

ACOs committed to addressing social drivers of health should strive to advance the success and viability of their CBO partners. Scaling services to meet new demand will require CBOs to move from a charitable model to a more dynamic financing model that covers their costs and adjusts to changes in demand for services. ACOs can help CBOs strengthen their operational capacity and financial position by facilitating relationships with payers, paying directly for services, contributing to joint research activities, and assisting with the technical aspects of contract negotiations. To build sustainable partnerships, ACOs must advocate for CBOs and work together with them to realize the full opportunity of integrating social and health care services.

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