BUSINESS ACUMEN CASE STUDY

Winning the Contract: New Revenue Stream for Community Organizations

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About the Network

The Partners at Home Network (PAH) is a growing statewide collaborative comprised of 22 public and private community-based organizations (CBOs) who serve clients through contracts with the Partners in Care Foundation, an NCQA-accredited nonprofit thinktank and service provider in San Fernando, CA.

The Foundation holds multiple service agreements with large healthcare entities such as medical groups and health plans. To expand the reach and impact of these agreements, the Foundation subcontracts with providers across the state to deliver services to eligible clients.

As the lead agency of PAH, the Foundation manages referral receipt and assignment, network-wide IT systems, program workflows and policies, and strategic business development. In addition to services, PAH members provide thought leadership around expanding and improving integrated care that address social determinants of health. PAH's purpose is to improve patient health outcomes by providing evidence-based care coordination, medication reconciliation, and health self-management services that reduce hospital readmissions and produce mutual financial benefit for both PAH and the payer; to integrate services that address social determinants of health, like environment and social and caregiver supports, into the continuum of care; and to create an innovative delivery system of community-based care.

Winning the Contract

To create a more integrated care system that recognizes and responds to health determinants beyond medical care—such as social services, care coordination, and environmental safety—CBOs are increasingly seeking and winning contracts with healthcare payers to serve

ACL Business Acumen Initiative

To enhance the readiness of community-based aging and disability organizations for contracting with integrated care entities, and prepare them for partnering to develop and implement integrated care systems, the Administration for Community Living (ACL) established its Business Acumen Initiative. As part of this initiative, learning collaboratives of well-organized networks of aging and disability organizations received technical assistance in marketing, contracting, service pricing, and other business areas. In addition, members of each collaborative shared relevant experiences, lessons learned, innovative ideas, and best practices for providing integrated care in a variety of community settings. Case studies such as this further ACL's aim to share models and information with communities and local agencies facing similar challenges.

patients inside and outside of hospital walls. Contracting with health payers means a new revenue stream for CBOs as well as a new avenue to reach those in need. The contracting process is new to many CBOs, and here we've shared our process and lessons learned.

Step 1: Build Relationships

June Simmons, MSW, had years of experience as a hospital social worker, rising to the position of Director for Patient Services and then moving to a CEO position in the largest home health agency in the U.S.—unusual for a social worker. For years, she was active in healthcare professional organizations, making contacts that would be crucial when the home health agency was sold and morphed into the Partners in Care Foundation.

Another crucial factor in building relationships was the Foundation's Board of Directors—strategically built to include strong voices within the healthcare sector capable of making additional important connections to potential payers. One of these relationships was with a physician who joined the corporate medical staff for a major health plan. The Chief Medical Officer of the plan had a background working in an integrated medical/long-term services and supports plan and was intrigued with the idea of community partnerships. After an initial high-level meeting, a small meeting of department heads established potential interest.

Step 2: Strut Your Stuff

As a follow-up to initial meetings, Foundation staff sent a list of services—evidence-based self-management programs plus a detailed list of each one of the components of its Medicaid waiver program (e.g., intake and assessment, Medicaid advocacy, navigation, benefits counseling, service coordination, purchase of service). In a 4-column document showing services, descriptions, durations, and outcomes, the Foundation used data about its own impact wherever these existed and reported research-based outcomes wherever its own measurement had not been possible. It focused on better patient outcomes, improved satisfaction and engagement, and lower utilization of expensive services (e.g., hospital). This was an excellent opportunity to demonstrate our speed and responsiveness, producing a document with tentative pricing over the year-end holidays, in preparation for a major meeting to be held a week later. The influence of the plan's CMO at this meeting was evident; other staff had taken evidence-based self-management programs off the list and with a word from the CMO, this service became a major focus.

The menu of service options evolved during contract negotiations, finally coalescing into a document that helped translate the services into the plan's way of understanding their members' needs: a breakdown of both the population and the services into tiers reflecting increasing risk and complexity of services.

Step 3: Contracted Services and Target Populations

The contract covers a menu of services including service coordination, evidence-based self-management, care transitions, and home evaluations. The three levels of service (tiers) have corresponding targeting criteria:

- *Tier 1 (lowest risk/fewest impairments):* Members can receive evidence-based self-management programs.
- *Tier 2 (moderate risk):* Members are offered in-home evaluations that include a computerized medication risk assessment and alert system called HomeMeds℠. Also included is a home safety evaluation and a psychosocial assessment with short-term care coordination called HomeMedsPlus. People recently hospitalized are also offered transition coaching and Rush University's Bridge Model social services as needed.
- *Tier 3 (highest risk):* Members with the most complex needs are offered a combination of services and care coordination with multiple home visits over 90 days.

Targeting criteria for each tier are based on issues such as: the number of chronic conditions, health literacy, disease self-management, caregiver issues, and prior hospitalization or emergency department (ED) use.

Step 4: Value Proposition

Results mattered. The Foundation presented excellent results for its existing care transitions programs and a HomeMeds℠-based contract with a major physician group, both of which produced a positive return on investment in the context of a quality improvement initiative.

We persuaded the physicians that some of the things we touch can influence the outcomes they care about: patient satisfaction, member retention, quality measures, and reducing ED and hospital use. Thus, we could present ourselves as a valuable and novel player composed of solid, experienced community agencies, as opposed to a "newbie" with no track record.

We spent a significant amount of time and resources helping the payer understand who the PAH members were, what they did, why the Network mattered, and how these new services provided by a different type of workforce could make a difference in their members' lives and in the payer's bottom line. By educating the payer on PAH's role, its potential for efficient regional and even statewide contracting, and its integral role in quality improvement with a positive ROI, we paved the way for PAH to be regarded as a business partner rather than a vendor.

Step 5: Closing the Deal

The timeline covered an estimated 10-month period from the initial informational sessions and telephone calls with decision-makers, to negotiation of contract terms, executing "playbook teams" to plan workflows and communication approaches, and implementation of the contracted services.

We spent about $40,000 on legal fees—way more than any other contract. This is, in part, because the population included Medicare beneficiaries. Medicaid rules are less stringent. IT security was a major component of the terms they imposed.

Unanticipated Challenges

Accreditation and the Medical Loss Ratio: Obtaining accreditation was a key step in keeping this contract deal. Both the California Department of Managed Health Care and the payer's own standards require that case management activities only be delegated to an accredited or licensed entity. Another reason for pursuing accreditation was the advent of the Medical Loss Ratio (MLR) provision of the Affordable Care Act that requires payers to spend 85% of premiums on clinical care and quality improvement efforts (e.g., case management). The Foundation's previous pilots had been paid with administrative funds, which under the MLR requirements are constrained to 15% of plan expenses. The Foundation is proud to have achieved complex case management accreditation through the National Committee for Quality Assurance. It was a costly, time-consuming, and challenging accomplishment, but one that has helped raise PAH's status as partner rather than vendor.

Champions at all levels: PAH needed champions inside the payer organization, both at the front end (contract negotiation) and at the implementation stage once referrals were received. We were able to identify an organizational champion and physician within the payer organization who had prior health management experience and who saw the direct benefit of social services to health. This is crucially important because there may be line staff resistant to change and perceived extra work—to the point of sabotage. Both peer champions and strong, committed managers can help overcome such resistance.

Building Referrals: Once the contract was in place, the experience of low referral volume highlighted a crucial need for strong working relationships with buy-in to the benefit of the contract and dedication to continuous improvement. Teams started with weekly operations meetings and still, eight months into the contract, meet every other week. The team now tracks referrals by each plan case manager to identify leaders/champions and those who appear to be less convinced of the value of the services. An unanticipated challenge leading to fewer referrals than expected was the plan's decision to randomize qualified members into usual care versus PAH interventions; thus 50% of potential referrals were lost immediately. Ultimately, IT solutions that automate converting quantitative targeting criteria into referrals may prove to be best.

Lessons Learned

Don't finalize pricing until you've read the entire contract. There were several unanticipated provisions that increased costs. For example, the contract required that an outside company perform member satisfaction surveys by phone. Also, IT security provisions involved an outside annual audit. Insurance requirements were higher than usual for a CBO – including "cyber" insurance (network security) and high umbrella limits. This was costly and has

proven to be a barrier for providers who might be potential network members.

Securing a contract with a large health plan can be costly. The Foundation spent more than $40,000 in legal fees and used an estimated 2,000 hours of executive-level staff time during the process, from introductions through day one of implementation. Additional expense was incurred to increase insurance coverage.

Insist on data sharing and collaborative planning for metrics. The path to more contracts depends on the ability to demonstrate results. It is important to agree on key measures for success and equally important that results be shared for quality improvement purposes and for future promotional activities.

Winning contracts may be easier than performance. Winning and negotiating contracts is fairly easy compared to building volume and managing the performance of a network. Persistence, charm, and excellence are needed to win over more resistant plan staff and address quality issues among friends within a network.

Use executive team and board members to your advantage. Foundation staff includes executives with experience in healthcare – hospital, skilled nursing, adult day health, hospice, and physician groups. The board has representation from health plans, medical groups, health systems, and hospitals, with skills including medicine, nursing, pharmacy, and consulting. Both the board and executive team have made important contributions to the contracting effort.

To learn more about business acumen and find tools to get started, visit the Aging and Disability Business Institute and the Disability Network Business Acumen Resource Center.