Resource Guide

Building a CBO Network for Health Care Contracting: Choosing the Right Model

In recent years, health care providers and health plans (payers) have come to recognize the impact the social determinants of health (SDOH) have on their patients' overall health, cost of care and their satisfaction with that care. Each of these has a clear relationship with a payer's success in achieving value-based performance metrics. As a result, many payers are increasingly motivated to better understand SDOH and are seeking solutions that address the social care needs and gaps of their members/patients. Additionally, growing numbers of payers are actively seeking proven, contract-based SDOH solutions from experienced community-based organizations (CBOs).

Why Networks Matter

For decades, CBOs working with older adults and people with disabilities have collaborated through networks to address SDOH and ensure person-centered social care solutions. Some, such as Area Agencies on Aging (AAAs), have built and managed networks of service providers to address their clients' SDOH needs and meet their agency's requirements under state and federal grants and contracts. However, much of this work historically has occurred in an independent silo, separate and distinct from health care payers.

To pursue opportunities with health care payers, many CBOs around the country are successfully creating a new type of network to help them more effectively work with health care. These networks organize their collective skills and scale to build common solutions, processes and technologies that address specific payers' SDOH-related problems and priorities. A **2020 survey**[i] conducted by the Aging and Disability Business Institute on CBO–health care contracting showed that the proportion of CBOs with one or more health care contracts through a CBO network has doubled since 2017. The reasons are relatively simple. Well-designed

and managed CBO networks can provide high-impact solutions that target payers' SDOH priorities for their clients, address most payers' desire for a simple contracting solution that covers their entire geographic region, and provides payers with a reliable infrastructure that can meet the payer's specific scope, skill, quality and consistency needs.

Key Terms and Roles

The U.S. Administration for Community Living (ACL) refers to these CBO networks as **Community Integrated Health Networks**[ii] (CIHNs). To be successful, a CIHN needs an organizational infrastructure through which participating CBOs coordinate and collaborate to ensure consistent services under existing and future payer contracts. ACL refers to these organizing structures as **Network Lead Entities**[iii] (NLEs).

CIHN	NLE
A CIHN is a coordinated group of CBOs led by a Network Lead Entity for the purpose of entering into contracts with a health care organization. [They] are scalable and can offer one-stop contracting for multiple proven interventions and services.	An NLE serves as the hub for coordinating the services of the wider network, provides a unified and consistent approach to program delivery across a geographic area, provides administrative oversight and takes the lead in governance responsibilities.

Source: https://acl.gov/sites/default/files/common/BA_roundtable_workgroup_paper_2020-03-01-v3.pdf

NLEs are typically legal entities, often nonprofit organizations. However, the underlying CIHN does not necessarily need its own legal structure and may simply be organized around a marketing brand that has been established by a collection of CBOs that share a common contracting relationship with the NLE (e.g., the Green River Home Care Alliance) referred to in this guide as CIHN-participating CBOs. NLEs and CIHN-participating CBOs providing services under contract with health care payers must recognize that their contracting activities take place under the auspices of federal, state and local antitrust laws and regulations. For more information on antitrust issues, visit the **Aging and Disability Business Institute's antitrust compliance policy statement**.[iv]

First Things First: Building a Foundation

Getting to operational readiness is challenging for many emerging NLEs and their CIHNs. Discussions among potential CIHN-participating CBOs about what forms a network should touch on the NLE's legal structure, governance, capital contributions and management and can be challenging. For this reason, an initial focus on the NLE-CHIN's form can distract from the more important goals of defining its function, building strong working relationships, enhancing data management capabilities, creating standardized and efficient processes, developing best practices, and infusing the NLE with a culture focused on developing and rewarding continuous performance improvement across all CIHN-participating CBOs.

To avoid these pitfalls, CBOs seeking to form an NLE-CIHN structure should begin with a shared vision such as how to secure payer contracts for transitional care across a particular metro area. Because form should always follow function, these initial discussions should focus on identifying and building consensus around the primary functions that will be consolidated across the NLE-CIHN. These may include product development, payer engagement, information technology (IT), and supportive administrative infrastructure in addition to the functions noted previously. Another key issue to address in these discussions is the need for minimum standard performance expectations across all CIHN-participating CBOs.

From this foundation, participating CBOs should develop the NLE-CHIN's contracting approach. Generally speaking, there are two approaches to consider: single contracting NLE or facilitator NLE. Features of both are listed in the table on page three.

With a clear understanding and agreement regarding the NLE's function, participants are well-positioned to determine the appropriate model the NLE should take to support successful operations. The three most common models NLEs should consider are described next.

- **Central Authority:** Typically, this is a stand-alone, independent nonprofit or for-profit organization whose primary purpose is to perform the NLE functions and lead the CIHN's contracting and execution efforts. A Central Authority NLE is not a subsidiary of a CIHN-participating CBO.

- **Lead Agency:** Under the Lead Agency model, typically a single CBO takes it upon itself to build the NLE functions in house or through a subsidiary nonprofit. The Lead Agency performs or contracts all NLE functions and forms the CIHN.

- **Federated Model:** Under this model, the NLE may be formed by a consortium of the CIHN-participating CBOs and most, if not all NLE functions are contracted to one or more of the CIHN-participating CBOs or through other vendors (e.g., accounting firm, technology vendor, etc.).

General Considerations

There is no right or wrong model. The particular needs and strengths of the CIHN-participating CBOs and other support organizations involved, along with the characteristics, diversity and equity needs of the communities served, as well as the potential needs and desires of prospective payers, should be carefully considered when choosing a model for your NLE. Existing NLEs should also periodically review the pros and cons of their critical functions and form to prepare for anticipated future needs and opportunities.

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Comparing and Contrasting Key Features

Authority and Task Management

Under the **Central Authority** and **Lead Agency** models, CIHN-participating CBOs place higher levels of authority in a separate legal entity (the NLE). Under in these models, the NLE has the authority to engage in ongoing business operations and decision-making that is distinct from, but in support of, the CIHN. As a result, CIHN-participating CBOs have the flexibility to focus on ongoing business operations while the NLE manages the business of contracting with payers and

NLE Approaches

	Single Contracting NLE	Facilitator NLE
How is the NLE marketed?	Marketed as single entity with multiple independent participants	Marketed as a collaborative among independent participating CBOs
How are CBOs contracted?	Single statewide or regional payer contract(s) with the NLE. CIHN-participating CBOs are contracted through NLE subcontracts.	Standard contract terms utilized by all CBOs participating in the particular CIHN service line
How are health care contracting opportunities pursued and evaluated?	NLE pursues specific opportunities at the governing body's direction	NLE identifies and evaluates opportunities for participants' consideration
How are health care contracting decisions made?	Non-competition agreement among participants with certain contracting authority ceded to the NLE by CIHN-participating CBOs	Final decision on any contract remains with individual CBOs, though the NLE and CIHN may craft a narrow set of specific reasons why a CBO might decide to not participate in a contract that is otherwise within defined parameters (e.g., lack of available staff)
Who sets performance standards?	NLE is responsible for ensuring participants' performance under the terms of each contract	The NLE-CIHN contract defines performance standards to which participants are expected to adhere; NLE provides support services on an as-needed basis
What is the process for billing and payment?	NLE bills and collects for services in its own name and then distributes funds to participants in a manner approved by the governing body; participants may share risk	Participants bill and collect for services in their own name (or through a third-party billing company); no risk-sharing among participants
How are operating expenses funded?	NLE's operating expenses funded through revenues (initial contributions may be treated as loans)	NLE's operating expenses funded by ongoing assessment on CIHN-participating CBOs

Key Features of Common NLE Models

NLE Model Characteristic	Central Authority	Lead Agency	Federated Model
Distinct legal entity	Yes	Optional	Optional
Representative governing body among CIHN-participating CBOs	Possible	Limited	Yes
Appropriate for Single Contracting Entity approach	Yes	Possible	Possible
Appropriate for Facilitator NLE approach	No	Possible	Yes
NLE start-up costs *(typically funded through CBO capital contributions)*	Highest	Moderate	Lowest
NLE contracting oversight responsibilities *(e.g., quality assurance and service delivery execution)*	Highest	Varies	Limited
Degree of CIHN-participating CBO engagement in NLE functions	Varies	Low	Highest
Use of shared services arrangements	Varies	Uncommon	Yes
Requires high level of trust and transparency	Moderate	Moderate	Greatest
NLE liability risks	Moderate	Greatest	Least
NLE as the vehicle to pool resources and coordinate activities among members as determined by those members	Possible	Uncommon	Yes
Degree of flexibility for participating CBOs	Low	Low	High
Degree of complexity to start	Greatest	Least	Moderate

overall network management. Of course, this freedom at the CIHN-participating CBO level means the NLE will have higher associated costs and will necessarily retain a greater share of the initiative's revenue as a reflection of the value of its services. The NLE will also exercise greater authority over certain performance aspects of CIHN-participating CBO operations as defined in its CIHN agreements.

By contrast, to succeed under a more collaborative and less formal Federated framework, CIHN-participating CBOs in a Federated model must commit to ongoing and active participation in consensus-focused decision-making regarding resources and coordinated activities. Typically, Federated model NLEs are formed through memoranda of understanding (MOU) among the participating CBOs. This MOU defines the process by which CIHN-participating CBOs will evaluate opportunities and agree to specific courses of action. These arrangements are known as compacts, which commit each participating CBO to conduct its business operations in a specific manner.

Some Federated model activities may be managed as tasks to be performed by one or more of the participating CBOs (with agreed-upon financial support from the other CBOs) rather than remain vested in a centralized NLE structure. For example, individual CIHN-participating CBOs may agree to retain a managed care contracting specialist and associated legal expertise, provide specific education and training, perform market research or lead negotiations with a particular payer. However, inherent with the Federated model's flexibility is its limited ability to enforce performance standards.

Another typical aspect of a Federated model is a shared services approach, which leverages existing operational expertise and capacity that may exist within one or more of the CIHN-participating CBOs. For example, one participating CBO may have strong billing and account management capabilities, proprietary care management software, or other data management and analysis capabilities that could be leveraged by all CIHN-participating CBOs. Leveraging this existing

capacity may reduce costs and complexity and strengthen uniformity without duplicating existing capabilities and associated overhead costs at the NLE or individual CIHN-participating CBO level. Central Authority and Lead Agency models may also engage in shared services arrangements, depending on demand for those services among CIHN-participating CBOs and the NLE's capabilities and resources.

Start-Up Costs and Expenses

In all three models, expenses are shared, albeit in different ways. Under a Central Authority model, start-up costs are high and typically shared by the CIHN-participating CBOs following an agreed upon common funding formula. Under the Lead Agency model, the lead agency may absorb some of the costs in the start-up phase, but it will expect to recoup those costs through fees or other advantages over time. In the Federated model, the highest costs for individual CIHN-participating CBOs are the extra time (potentially a considerable amount of time) they must spend actively participating in the group's collective and ongoing operational decisions and the cost of each CIHN-participating CBO maintaining duplicative administrative functions (in the absence of shared services arrangements). The greatest concerns with the Federated model are an inability to reach timely decisions and a lack of consensus on critical issues. No matter which model is selected, formulas are needed to ensure the costs associated with services performed directly by the NLE or through shared services arrangements are equitably distributed across the CIHN-participating CBOs.

For CBOs launching a new NLE-CIHN structure, the Federated model may offer a lower initial cost approach by limiting the need to develop costly new NLE infrastructure while the CIHN is in development and associated revenues are limited. This form also allows the CBOs involved to focus on the critical working relationships among CIHN-participating CBOs. However, as noted above, it does require a fairly high level of time commitment for active collaboration. The opposite is true with a Central Authority model (NLE). While requiring the least active engagement from participating CBOs, it risks creation of inherent administrative duplication and associated costs, unless it uses shared services. A Lead Agency model falls in the middle on startup costs, as long as the lead agency has excess administrative capacity to absorb the additional responsibilities.

It's Not All or Nothing

Of course, blending features from two or all three of these NLE-CIHN models is not only possible, it is likely to occur. As the NLE and CIHN-participating CBOs gain experience and needs change, the NLE may add features or evolve into a different model to reflect organizational needs over time. For example, a lead agency may spin-off the NLE functions into a stand-alone Central Authority if conditions warrant. By contrast, loss of an NLE's major payer-client may require it to dissolve much of its capacity and return to a Federated structure to save capital and respond to the new operating environment.

No matter which function and form decisions are made, one thing is clear, participating in an NLE-CIHN initiative is increasingly essential to CBO-payer contracting success. For additional information on NLEs and contracting, visit the **Business Institute's Contracting Toolkit**.[v]

Endnotes

i *Strengthening Ties: Contracting Between Community-Based Organizations and Health Care Entities*, Scripps Gerontology Center of Miami University of Ohio, Suzanne Kunkel, Traci L. Wilson, Abbe E. Lackmeyer & Jane K. Straker, https://sc.lib.miamioh.edu/bitstream/handle/2374.MIA/6675/strengthening-ties-contracting-between-CBOs-health-care-entities.pdf?sequence=4&isAllowed=y.

ii *No Wrong Door Community Infrastructure Grants: Scaling Network Lead Entities*, U.S Administration for Community Living, https://acl.gov/grants/nwd-community-infrastructure-grants-1.

iii *Community Integrated Health Networks: An Organizing Model Connecting Health Care & Social Services,* U.S. Administration for Community Living, https://acl.gov/sites/default/files/common/BA_roundtable_workgroup_paper_2020-03-01-v3.pdf.

iv *Antitrust Compliance Statement*, USAging's Aging and Disability Business Institute and Comprehensive Care Connections, https://www.aginganddisabilitybusinessinstitute.org/adbi-resource/antitrust-compliance-policy-statement.

v *Contracting Toolkit*, USAging's Aging and Disability Business Institute, https://www.aginganddisabilitybusinessinstitute.org/adbi-resource/contracting-toolkit.

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This publication was produced for the Aging and Disability Business Institute by Martie Ross (PYA, P.C.) and Paul Cantrell (Clear View Strategies, LLC). 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 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****.*

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