

# Resource Guide

## *How to Build the Business Case for CBO Services*

### Background

The financial landscape for community-based organizations (CBOs) is shifting. As health care systems become more organized around quality and patient outcomes, a corresponding shift is driving change in the way social services are organized, delivered and financed. This leads to new CBO business opportunities that go far beyond traditional government programs and foundation grants, opening the door for collaborations at points of care where social service integration can improve an individual's health and quality of life while delivering positive financial outcomes for payers.

To leverage these opportunities, CBOs must become comfortable with new ways of financing, measuring and managing their services. Successful CBOs will develop offerings that drive positive outcomes and deliver a meaningful return on investment (ROI) for their health care partners that provide incentives for both organizations.

### Social Determinants of Health

Mounting evidence<sup>1</sup> supports the idea that factors outside of the clinical environment drive the majority of health care costs. Increasingly, health care payers and providers are seeking opportunities to better address the social determinants of health such as food security, housing instability and quality, and access to transportation and utilities such as electricity and gas. This is occurring at the same time that Medicaid and

Medicare programs are emphasizing the importance of integrated care. As a result, the need to address social needs as an integral component of health care is becoming more accepted, particularly as it applies to people with disabilities and older adults.

As health care executives move their organizations towards integrated care and come to recognize the need to address social needs that impact their patients' health, CBOs are presented with an urgent opportunity to offer solutions to fill the service and support gaps that can threaten an individual's health.

Managed Care Organizations (MCOs), health systems and other payers are designing and experimenting with new covered services to meet these person-centered goals, including: care transition processes, community health navigators, chronic disease and other evidence-based patient self-management programs, mobile technology monitoring, family caregiver supports, falls prevention programs, movement and exercise classes, nutrition services, transportation options, home modification services and more. CBOs wishing to contract with these entities to deliver such services must consider how their existing services address the social determinant gaps faced by patients and be prepared to discuss the value and experience they have delivering those services to support an individual's health. These CBOs must also be prepared to design and measure how those services might be delivered, integrated and priced under managed care. Some examples are described in greater detail on the Aging and Disability Business Institute's website.<sup>2</sup>

1. More information is available at <http://www.countyhealthrankings.org/sites/default/files/differentPerspectivesForAssigningWeightsToDeterminantsOfHealth.pdf>.

2. <https://www.aginganddisabilitybusinessinstitute.org/category/success-stories/>

# Competing in the New Health Care Environment

## Step One: Identify Strategic Value

Every CBO should candidly assess its strengths by asking questions such as:

- What are my CBO's best programs—programs (including design and execution) that could serve as a model or best practice?
- In what ways is my CBO strategically situated to deliver value?
- Does my CBO have expertise and capacity in programs or services that no other CBO could provide if my CBO ceased to do those things tomorrow?
- Where does (or could) my CBO have a significant, positive impact on health outcomes and quality? This may require an analysis of client data.

As they seek to evaluate opportunities and develop service offerings, it is critical that CBOs take a hard and honest look at potential competitors (such as other local CBOs, including those in the CBO's current sub-contracted network of providers, and potential future entrants into the space).

**CBOs must be clear and specific in articulating value. This is no time to be modest!**

With the aging of the baby boomer population, older adults are becoming an attractive market to target. Companies are emerging that believe they can do what CBOs do—better, more quickly and at a lower cost. As a result, all CBOs should perform a market analysis and prepare to offer competitive products to maintain their “market share.”

Competition is a new paradigm for most CBOs and will present both challenges and opportunities. It also underscores the need for CBOs to do their homework by using this competitive analysis to inform planning during the development of compelling and competitive product offerings.

Based on these internal discussions, a CBO should develop a value statement that clearly articulates its strengths and answers the question of why potential clients or payers should purchase its products and/or services. CBOs will need to understand the local health care environment to determine what services it will offer (e.g., is non-emergency transportation a major health care barrier in the community? Does the community have a scarcity of appropriate housing?)—and how these products and services will address those gaps and deliver value.

Another consideration for CBOs is how to engage potential provider network partners. In large part, this will be determined by the CBO's internal capacities, goals, strengths and vision. For many CBOs, this will require a close and critical assessment of its service provider network to understand its capabilities, capacity and willingness to work together to seek new partnerships with health care providers and payers. Pricing strategies will follow from these assessments.

## Step Two: Assess Leverage

In order to assess its leverage, a CBO must examine its market share compared to that of its potential competitors, and evaluate any leverage it may have when negotiating with health care providers and MCOs. If, for example, an MCO is legally required to include services provided by a CBO in its network, and there are local few providers offering those services, then the MCO will be more likely to respond positively. A CBO is in a better position to set its terms and prices if it has more market share and fewer viable competitors.

Data is another critical element. It isn't enough for a CBO to show that it has experience delivering a particular service. CBOs need to track performance and client outcomes. In order to do so, CBOs should consider tracking measures such as:

- Service response time expectations and how often a CBO achieves those metrics.
- The percentage of a CBO's transportation clients that are present for their medical appointments.
- The percentage of a CBO's post-discharge meal delivery clients that are readmitted to the hospital for complications, especially due to a lack of adequate nutrition.

Most important is the “so what?” factor. What was the result for the client? How did a CBO’s service positively impact a client’s health and quality of life or help the client avoid unnecessary costs? Being able to track and discuss how CBOs deliver in these areas may be the single most important component in a CBO’s value proposition, which is central to the amount of leverage a CBO has or doesn’t have.

CBOs must also consider the intangibles. For example, MCOs are large and often have many more employees than the typical CBO. However, few will have the depth and breadth of knowledge that a CBO and its employees have about the community in terms of the clients served, community leaders, and the reputation of the service providers. A CBO should not discount the value an MCO may receive by aligning with a CBO for these and other intangible community connections and relationships that the CBO has developed over many years—it may help open doors as CBOs approach potential new partners.

### Step Three: Make the Business Case

The definition of a **business case** is the justification of an organization’s (the buyer’s) expenditure based on the positive economic consequences to the buyer.<sup>3</sup> In addition to the business case, CBOs can make light of other benefits:

- The **health** case: The service has intrinsic value. It will achieve its stated outcomes related to health and well-being. A CBO must do its homework by learning about any metrics it must achieve. If a CBO can help the organization meet its health-related metrics, it may receive incentives or positive news that provides them with real value—market differentiation.
- The **social** case: The service creates social value. It results in economic benefits, irrespective of to whom they accrue, that exceed the costs.
- The **intangibles** case: As noted in Step Two, a CBO may possess a strategically valuable intangible through its relationships and intimate knowledge of and experience working in the community and with the available long-term services and supports

(LTSS) providers that a payer may find valuable (and be willing to pay for).

But to make a business case, CBOs and other providers will need to **demonstrate evidence of financial value to their MCO payers**. The business case involves a **cost-benefit analysis**. The benefits must be expressed in dollars.

**One way CBOs can describe the value of a service for payers is to articulate the impact on cost avoidance (e.g., keeping the individual out of the emergency department and/or hospital). Examples well known to many CBOs include: nursing home diversion programs, respite care, care coordination, care transitions, evidence-based programs, palliative care and person-centered care.**

To negotiate effectively in bilateral relationships with MCOs, a CBO’s business case must address the question, “Is there an adequate return on investment?” In other words, will your proposal lead to a measurable financial benefit for the MCO? To calculate its ROI, a CBO should:

- Measure and add up the expected benefits in terms of cost savings plus any revenue enhancements to calculate “gross” benefits.
- Estimate the total costs of the program.
- Subtract these costs from the “gross” benefits to get “net” benefits. Another term for ROI, net benefits often are expressed as a percentage of the program costs .
- Compare the ROI to a “hurdle” rate, a minimum percentage that any investment must generate in order to be considered by potential buyers. Remember, buyers will likely consider multiple options for investing finite resources. It isn’t enough for CBOs to simply show ROI, the buyer must find the ROI attractive when compared to the CBO’s competitors and alternative investments.

3. From “Preparing Community-Based Organizations for Successful Health Care Partnerships: How to Make the Business Case,” part of the National Aging and Disability Business Institute Series, with Victor Tabbush, Ph.D. Available at <https://www.aginganddisabilitybusinessinstitute.org/resources/preparing-community-based-organizations-successful-healthcare-partnerships-make-business-case/>

## Step Four: Strengthen Negotiating Skills for Contracting with MCOs

As stated in Step Two, assessing leverage is a key component of a successful negotiation.<sup>4</sup> CBOs should know (and make sure the MCO knows) its internal strengths and abilities. A CBO should also recognize its weaknesses and be prepared to address them in negotiation if necessary.

Assessing leverage also includes an evaluation of the MCO's background and fitness. CBOs should examine elements of the MCO's operation and its standing with the state Medicaid program and/or Medicare, depending on what type of contract it is pursuing. If the MCO has received negative media or has low quality scores, a CBO may be valuable as a key provider to help boost the MCO's performance while offering intangible strengths through its value proposition.

**Most MCOs offer a “standard contract.” Do not assume that the provider must accept this contract wholesale! However, remember that large entities value standardization as it breeds efficiencies and improves success in execution.**

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4. CBOs can find additional tools and resources about negotiating contract terms with MCOs, including a checklist, negotiation strategies, information on when to step back from negotiations and more in “Technical Assistance: Negotiating Contracts with Managed Care Organizations,” Adam J. Falcone, <https://careacttarget.org/library/negotiating-contracts-managed-care-organizations>.