Resource Guide

Frequently Asked Questions for Building a Strong Data Driven Business Case for Health Care Contracting

As community-based organizations (CBOs) engage in contracting with health care entities, becoming familiar with commonly used financial terms can help them prepare for those opportunities. By helping CBOs understand key terms and concepts for determining the financial viability of potential new partnerships, this resource provides answers to some of the most frequently asked questions and provides a foundation that CBOs can use to build a strong data-driven business case.

Return on Investment (ROI)

Should the improved health outcomes from the CBO's social service intervention be considered part of the ROI?

No. The ROI is a financial metric that isolates the beneficial financial results accruing to the health care entity being asked to invest in the social care services provided by the CBO. The intrinsic worth of such services, (i.e., the benefits to the client/patient/family) are not part of the ROI, although such benefits are crucial to deliver. These non-financial benefits accruing to others, while not part of the ROI, may be cited by a CBO to help convince a health sector partner that offering social care services is the right thing to do, regardless of the ROI.

Why might a positive ROI not be enough to win a contract?

In some cases, when resources are scarce, the ROI for a CBO's social care services may not be sufficient enough to compete with other investment opportunities that may be more financially attractive to a potential health sector partner.

Making the Business Case

How can my CBO present a more compelling business case?

The data your CBO presents should provide clear evidence of the positive financial aspects of the service it provides. Additionally, you can make your presentation persuasive with some audiences by adding elements that are not strictly about ROI. First, while the intent is to focus on the *instrumental* value of the activity, it is worthwhile in this business context to emphasize what the program means to the recipients—its *intrinsic* value. In your setting, it is unlikely that your audience is indifferent to the qualitative benefits accruing to the individual and their family. Second, if there is a sense of urgency, it is good to emphasize that implementing your services now can prevent worsening conditions down the road.

How do non-financial outcomes such as improved beneficiary satisfaction from a successful partnership with a health care entity figure into the business case?

A business case is usually built on a solid financial base—benefits are converted into dollar terms. However, soft ROI, which is based on the qualitative benefits, can support the case for why your CBO's services are important to the beneficiary and the potential positive impact on their overall health outcomes. When the decision of whether to invest in a contract with your CBO is a close call, citing these added benefits, while not quantifiable, can help encourage a health care entity to contract with your CBO.

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Which financial factors support the business case social service investment?

Many factors influence the strength of your business case, but most important is the degree of success or effectiveness your CBO's business case makes in showing that it can provide a direct financial benefit to a health care partner, such as a reduction in utilization and the cost of medical care and or a revenue boost.

Another factor exerting influence on the strength of the business case is the cost of the service sold to the health sector investor—the less expensive it is, the stronger the case for it. In fact, if the cost were zero, the ROI might be infinite!

A third significant factor is a financial burden that can come with deviating from the status quo. If that financial burden is heavy, initiatives to lighten it have good financial potential.

Risk

How best do I recognize the risk from uncertainty in business case calculations?

The simplest way to assess the riskiness of a ROI estimate is to create scenarios, each with a unique set of assumptions. Start by making an ROI estimate using the most likely input values; then create a second scenario, one in which the inputs are set at plausible—yet less favorable levels (resulting in a lower ROI). The third scenario is where input values are set at their most optimistic bounds, resulting in a more favorable higher ROI. All three of these scenario results are organized and reported as an ROI range.

Budgeting/Costing

When operating with limited resources, are cost-neutral service offerings worth investing in for a potential health care partner?

It may be the case that if the effort does not drain resources, it does not have to add to them either. This depends on the value and financial condition of the health care partner as to whether cost-neutrality is an acceptable result. However, it should be expected that something more than cost-neutrality will be demanded.

Why do some financial officers demand to see a benefit-to-cost ratio of three (or more) to one before approving an investment?

Financial officers are trained to be skeptics of financial promises such as those embedded in a high benefit-to-cost ratio. They may correctly believe the projected ROI is inflated for clinical advocates to have their programs approved. Another reason is that the result is subject to a significant degree of uncertainty, and therefore, the investment is inherently risky. To compensate for this risk, a higher return may be required.

My CBO has four staff members who provide care transition services to hospitals under an ongoing contract. We have found that the cost of delivering these services is more than we had anticipated and my CBO is losing money as a result. What can we do?

One idea to explore is how the service delivery process varies across the four providers. It is unlikely that all four operate the same and have equally efficient processes that they follow. Look for best practices, and then have the others adopt those identified as the leanest. Variation is an indication of waste, and by eliminating it and standardizing the process with the best-in-class, your cost may shrink to levels that make the service profitable. It may be a good idea to renegotiate the fee from the hospital, if possible.

Determining Service Offering

How do you estimate costs for new services?

CBOs should use the time-based activity costing method to estimate any service cost, new or old. This approach makes sense when the dominant cost of the service is the time expended. This approach involves mapping the entire service delivery process. There will be many steps, and each step will involve a set of activities. Identify the staff person's skill level to implement each activity along with the corresponding hourly cost of that person's time. Then, the number of minutes or hours that each activity takes and the number of times the activity is performed need to be estimated. In addition to the time required, consider the expenses of any materials and supplies required for operating the service. If the service requires start-up expenses such as information technology configuration or training, these too need to be accounted for. It is best to pay off one-time-only expenses over the expected duration of the program rather than attribute these costs to the program's first year.

Identifying Potential Health Care Partners

My CBO is interested in offering care transition services to hospitals. How should my CBO identify and target hospitals that could most benefit from contracting for care transition services?

Target those hospitals that have excessive readmission rates and are being penalized by the Centers for Medicare & Medicaid Services (CMS) under the Hospital Readmissions Reduction Program. Find the readmission rates for any hospital using CMS data.[1]

How can my CBO identify medical groups that have the largest incentive to contract with CBOs for fall prevention programs?

Medical groups contract with Medicare Advantage plans to deliver clinical services that the plans are obliged to cover. The contracting terms will vary, but one crucial feature is the degree of financial risk the plan delegates to the group. The more significant the proportion of the total cost of care the group assumes responsibility for, the greater the incentive there is for the group to discover ways to reduce expensive medical utilization, such as emergency room visits attributable to falls-related injuries. Therefore, the incentive is strongest among groups that have been capitated by the plan and assume responsibility for in-patient and out-patient expenses. To understand what those contracting terms might be, CBOs should think about accessing expertise from health care payors. Consider if someone on your board of directors has this insight.

This publication was produced by the Aging and Disability Business Institute at USAging. 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****.*

1 Centers for Medicare & Medicaid Services, Hospital Readmissions Reduction Program Data Explorer, **https://data.cms.gov/provider-data/dataset/9n3s-kdb3**.