

Resource Guide

A Lexicon of Contracting Terms

Introduction

This Resource Guide is intended to be used as a catalog of common terms that aging and disability community-based organizations (CBOs) will likely encounter as they work with health care entities. This lexicon is part of the Aging and Disability Business Institute's (Business Institute) Contracting Toolkit, which includes the *Contracting Dos and Don'ts* and the forthcoming *Insurance in Contracting Resource Guides*. As the toolkit grows, so too will the lexicon. Every attempt will be made to use these terms consistently across all resources in the Contracting Toolkit. However, please be aware that links to external materials and resources may be provided without assurance that those resources use the same terms in a consistent manner. Have a question about the lexicon or a request for a term to be added? Please email us at businessinstitute@n4a.org.

Terms

Accountable Care Organization (ACO): ACOs are groups of doctors, hospitals and other health care providers that agree to coordinate and deliver the right care for patients at the right time, while avoiding unnecessary duplication of services and preventing medical errors. To reduce costs and improve the quality of care, ACOs often focus on prevention and helping patients better manage their chronic conditions.

More information: www.innovation.cms.gov/initiatives/ACO

Acquisition Costs: The costs (financial, time and other resource costs) associated with acquiring a new client. The term "client" in this instance could include anything from a Managed Care Organization (MCO; definition on page 5) to an individual member of the pool of clients your CBO is under contract with the MCO to serve.

Example: Acquisition costs rely heavily on understanding the daily average of time spent per potential patient, the volume of patients available as potential clients to be seen every day, and the ratio of patients seen to permissions secured is essential to helping CBOs determine acquisition cost.

Alternative Payment Arrangements or Models: See Financial Risk on page 3.

Area Agency on Aging (AAA): AAAs are governmental or nonprofit entities designated by the state as the local planning, development and coordination organizations for aging services. AAAs were established under the 1973 amendments to the Older Americans Act (OAA) to respond to the needs of Americans ages 60 and older in nearly every community across the U.S. By providing a range of programs and services that allow older adults to choose the home and community-based services (HCBS) and living arrangements that suit them best, AAAs make it possible for older adults to age in their homes and communities for as long as possible.

More information: www.n4a.org/aaastitlevi

Business Associate (BA): An individual or entity that contracts with a Covered Entity (see definition on page 2) as part of a business arrangement that involves the Covered Entity sharing Protected Health Information (PHI; definition on page 6) with the individual or entity. In such an arrangement, a Business Associate Agreement (BAA; see definition on page 2) is mandatory under Health Insurance Portability and Accountability Act (HIPAA; definition on page 3) privacy rules (definition on page 6). Business Associates are also known as Downstream Providers.

More information: www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/index.html

Business Associate Agreement (BAA): A BAA is a signed, standalone agreement, exhibit or addendum to a contract that is issued by a Covered Entity (definition on page 2) to any Business Associate with which the Covered Entity intends to share protected health information (PHI; see definition on page 6). Covered entities are required by HIPAA privacy rules to execute a BAA with any Business Associates or Downstream Providers (see Business Associate definition on page 1) with which the Covered Entity intends to contract to provide services to individuals on behalf of the Covered Entities that involves any disclosure of PHI.

The BAA provides contractual assurances that the Business Associate will: use the information only for the contracted business purpose; cooperate with the Covered Entity on compliance measures; and protect the privacy of the PHI as required by HIPAA. The BAA should list the obligations and responsibilities of the Downstream Provider and the Covered Entity as they pertain to the protection and use of PHI, overall HIPAA compliance and related privacy laws in the execution of the work.

More information: www.hhs.gov/hipaa/for-professionals/covered-entities/sample-business-associate-agreement-provisions/index.html

Cause: Also known as “for cause.” A legal term meaning for a legitimate, specific reason, or with justification. Cause is often used in the context of contract termination provisions to provide a basis for contract termination for a breach or other dangerous, unlawful or inappropriate action of the other party.

Centers for Independent Living (CILs): CILs are “consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agencies” designed and operated within a community by individuals with disabilities. CILs provide a variety of independent living services, such as information and referrals as well as transition assistance from nursing homes and other institutions to community-based residences.

More information: www.acl.gov/programs/aging-and-disability-networks/centers-independent-living

Community-Based Organization (CBO): A CBO is an organization with a mission to serve the social service needs of individuals in that organization’s community.

Typically, a CBO is a public or private nonprofit organization.

Note: Within this Contracting Toolkit, use of the term is narrowed to refer specifically to CBOs pursuing the types of contracting opportunities that are the focus of the Business Institute’s work, such as AAAs, CILs and other community-based aging and disability organizations.

Confidentiality Agreement (CA): See Nondisclosure agreement (NDA) on page 5.

Covered Entity: According to the U.S. Department of Health and Human Services (HHS), Covered Entities include “health plans, health care clearinghouses and certain health care providers.” Covered Entities are directly subject to HIPAA privacy rules and are thus required to execute a BAA with any Downstream Provider with which the Covered Entity intends to contract to provide services that involve any disclosure of PHI to that Downstream Provider.

More information: www.hhs.gov/hipaa/for-professionals/privacy/guidance/business-associates/index.html

Downstream Provider: See Business Associate on page 1.

Endorsement: An endorsement, also known as a “rider,” is a document attached to a contract or policy that amends the policy in some way. It may add, remove or alter the scope of coverage under the policy. For example, a homeowner’s policy may have an endorsement attached that outlines (aka “Schedules”) specific items that are, or are not, covered under the policy, such as loss from flooding. Such endorsements may increase or decrease the overall policy premium based on the risk exposure increase or decrease.

Exclusivity: An exclusivity clause (also known as a “noncompete”) is a contract provision that restricts the signer from buying, selling or promoting specified goods or services in specific ways. Such provisions typically include time and geographic limits. In other words, the restricted party works exclusively with the issuer of the contract.

Example: At all times while providing services under this agreement and for a period of 12 months thereafter, [agency] shall not perform the same or similar services for businesses that compete with [client] in this state.

Fee for Service (FFS): A fee structure based simply on the concept of providing a specific payment (fee) for a specific service delivered. Historically, many health care providers and CBOs have been paid on a FFS basis.

***Example:** Meals provided under a home-delivered meals program are often paid under a FFS arrangement and expressed as \$X per delivered meal or per meal delivery.*

The state pays the agency \$Y dollars per 15 minutes of billable service coordination time.

FFS can provide CBOs with a good way to get started in health care contracting. For organizations that are already providing a desired service, FFS arrangements may be an easier way to develop initial pricing models. Some health systems and health plans may be willing to compensate CBOs with FFS for some services.

Financial Risk: Financial risk sharing is a payment arrangement in which providers become partially or fully financially responsible for the services they provide. These types of payment arrangements are often collectively referred to as “alternative payment models” because they offer alternatives to the traditional FFS model and in most cases, shift some or all of the risks associated with unknown volume or complexity to the Downstream Provider. These arrangements are often used to incentivize Downstream Provider behaviors to encourage quality and efficiency. However, not all financial risk structures are the same.

1. **Upside risk:** This model provides incentives to the CBO or other Downstream Provider based on how it performs on financial or other pre-defined benchmarks. If actual costs exceed the benchmark or if quality is below the benchmark, Downstream Providers in upside risk-only models do not qualify for the incentive payments—but they are also not financially penalized as is the case in a downside risk model.
2. **Downside risk:** This model includes financial penalties or related exposure or “withholds” to your CBO for failure to meet specific contract requirements and metrics.

Full-Time Equivalent (FTE) Based Payment: A formula wherein an MCO contracts with a CBO for a set rate for each of the CBO’s employees that are assigned to work with that MCO on a full-time equivalent (FTE) basis.

***Example:** The CBO agrees to make available to the MCO a predetermined number (or range) of service coordinators to work full time and exclusively with the payer’s clients/members.*

An FTE-based payment model is akin to an employee leasing arrangement, such as a per member, per month (PMPM; definition on page 5) pricing model. However, FTE arrangements shift some of the risks associated with volume variation to the MCO. FTE arrangements also limit the CBO’s flexibility in staffing and raise issues of coverage when employees are on vacation or have resigned, as well as CBO supervisory and administrative support functions. Just as with the PMPM approach, understanding the details behind rate assumptions is essential to ensuring that a CBO considers all costs associated with the work in order to arrive at an acceptable price.

Health Information Technology for Economic and Clinical Health Act (HITECH): HITECH is part of the American Recovery and Reinvestment Act (ARRA) of 2009 and creates incentives related to health care information technology. HITECH encourages the adoption and protection of electronic medical records and data exchanges and also strengthened the privacy and security provisions in HIPAA (definition on page 4) for the digital age. It creates a framework to ensure the confidentiality and integrity of PHI and simultaneously strengthens the regulatory framework regarding PHI protections and safeguards. Through HITECH, Business Associates (see Business Associate Agreement on page 2) can now be held directly liable for HIPAA violations.

More information: www.hipaajournal.com/relationship-between-hitech-hipaa-electronic-health-medical-records

Health Insurance Portability and Accountability Act (HIPAA):

The Health Insurance Portability and Accountability Act, passed by Congress in 1996, does the following:

- provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
- mandates industry-wide standards for health care information on electronic billing and other processes;
- requires the protection and confidential handling of PHI; and
- reduces health care fraud and abuse.

It is Title II of HIPAA that provides patient privacy protections and security controls for health and medical records and other forms of PHI.

Health Plan: See Managed Care Organization (MCO) on page 5.

Hold Harmless Agreement: Also known as “Hold Harmless Clause” or “Release of Liability,” a Hold Harmless Agreement is a legal agreement that is used to protect one or both parties under contract. It stipulates that one party will not hold another party liable for risk or damage. A Hold Harmless Agreement can be a one-way (unilateral) or two-way (reciprocal) agreement. For contract or service providers, the hiring party will often ask those working or providing services under a contract to sign a release.

Home and Community-based Services (HCBS): Home and Community-Based Services include a variety of person-centered social services provided to individuals, primarily for the purpose of assisting them with everyday activities that help them increase well-being and improve or prolong the individual’s ability to remain in their chosen home or community living setting.

More information: www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/hcbs. The Administration for Community Living also hosts a glossary of terms that closely relate to these services, which may be found at www.acl.gov/ltc/glossary.

Integrated Health System (IHS): An IHS is an organized group of health care providers and facilities, usually based around a hospital or hospital system. Typically, most if not all of the health care providers and facilities within the IHS are under common ownership or an alternative business model that binds the organizations together through contracting or other financial arrangements.

***Example:** A hospital forms a physician group that primarily or exclusively refers patients to other organizations within the IHS, including to other doctors, outpatient diagnostic testing centers, outpatient surgical centers, etc.*

Letter of Intent (LOI): A letter of intent is a non-binding declaration of the party’s intent to do what is stated in the letter. These are often collected by MCOs when they are bidding for a large contract and need to demonstrate their ability to build a contracted network of providers (consisting of health care and/or CBOs) if the MCO is subsequently awarded the contract that is the subject of the request for proposals (RFP). Using LOIs is more efficient for all parties. However, CBOs should only provide LOIs to MCOs and other entities with which they have an interest in contracting for the services contemplated and have a reasonable level of assurance that achieving a contract is both desired and likely if the bidder is awarded the contract. Consider this an early negotiating tool to establish intent and a basic framework that should be carried through and consistent with the MCO’s commitments in the written bid submission. See also Memorandum of Understanding (MOU) on page 5.

Liquidated Damages: A liquidated damages clause specifies a predetermined amount of money that must be paid as damages for failure to perform under a contract. The amount of the liquidated damages should be the parties’ best estimate at the time that they sign the contract of the damages that would be caused by a breach or other failure to perform. Liquidated damages can act as a type of insurance against the cost of a breach. By deciding on damages at the outset, both parties have the opportunity to settle on an amount they think is fair instead of leaving this decision to be settled in court or arbitration—which can be time-consuming and costly.

Managed Care Organization (MCO): Organizations licensed by state insurance departments to engage in the business of health insurance (including health maintenance organizations and health plans). MCOs may offer Medicaid managed care plans, Medicare Advantage (Part C) plans, Medicare Prescription Drug Plans (Part D), commercial (employer and union-based) group health plans, individual health plans and TriCare.

***Note:** For simplicity, the acronym “MCO” is used throughout the Contracting Toolkit as a proxy for any and all similar payers.*

Memorandum of Understanding (MOU): A nonbinding agreement between two or more parties outlining their intentions. Typically, the MOU formalizes the parties’ intent to form a working relationship that may or may not result in a service agreement. While an MOU is not a binding contract, it is often the first step towards a contract and is typically used to demonstrate to a third party the seriousness of a party’s intentions. Typically, an MOU is a more detailed version of a LOI. However, some organizations use the terms interchangeably. A sample MOU can be found on the Aging and Disability Business Institute website at www.aginganddisabilitybusinessinstitute.org/resources/sample-memorandum-understanding-mou-lead-community-based-organization-cbo-subcontractors.

***Example:** An MCO securing MOUs from CBOs and health care providers is the first step toward creating a provider network. The MOU will typically outline the framework of the potential agreement, general service area, etc.*

Non-Compete Agreement: See Exclusivity on page 2.

Non-Disclosure Agreement (NDA): Also known as a confidentiality agreement (CA), an NDA is a contract provision or standalone legal contract by which two or more parties agree not to disclose non-public, confidential material, knowledge or information that one party shares with the other party as a necessary part of business exploration, contract negotiations and during the course of routine business. An NDA is often the first legal agreement two entities execute as part of discussions regarding the potential benefits to each organization. NDAs allow parties to disclose competitively sensitive information to one another with protections in place to ensure that

neither party inappropriately uses such information for any other purpose. CBOs should ensure that any NDA they sign is a mutual (or bi-directional) NDA that protects both parties.

Party: One of the entities that is part of an agreement. In the context of health care contracting, both MCOs and CBOs are parties. Organizations referenced (generally or specifically) in the agreement’s scope of work are not parties under the agreement unless the organization is specifically identified as such and legally commits to be bound by the terms of the agreement.

***Example:** An MCO and CBO enter into a contract whereby the MCO contracts with the CBO to perform care transition services for the MCO’s members being discharged from a named hospital. The hospital is not a party to the agreement unless it is named as a party in the agreement, has responsibilities and compensation (not necessarily monetary) enumerated in the agreement, and one of the hospital’s executive officers agrees to and signs the agreement.*

Per Member, Per Month (PMPM): A PMPM fee structure means that an organization will be paid a set price per member per month for a given population. It is important to understand the characteristics of the initial and potential future individuals in the population (in terms of number of individuals, their geographic location, health and social service needs characteristics, etc.) for which the CBO will be compensated under the PMPM arrangement.

***Example 1:** The PMPM could be for the MCO’s entire membership, even though the CBO is only required to provide services to participants who request the service.*

***Example 2:** The PMPM could be structured to pay only for the MCO members assigned to the agency or a subset from which the agency secures consent to receive the agency’s services.*

The two examples above illustrate how changing the definition of the population results in vastly different costs and payments to the CBO. Therefore, it is critical that CBOs understand exactly which services the MCO is asking your CBO to provide within the scope of that fixed monthly payment and the population (volume) for which it will be paid. Understanding your acquisition costs under the arrangement is also critical.

Point of Contact (POC): Contracts most often contain two or sometimes three POCs:

1. **Executive contact:** This is typically the person signing the agreement. For CBOs that require the signature of the CBO’s board chairperson or county executive to execute a contract, this might be the CBO’s Executive Director.
2. **Routine or day-to-day contact:** This person has the primary, ongoing responsibility for execution of the contract’s work requirements. This may be a department director or project manager.
3. **Registered agent:** Also known as “Agent for Service of Process,” this individual has been designated to receive legal communications, such as notice of contract termination, on behalf of the organization. In most cases, this is the organization’s legal counsel or, for CBOs that do not have retained or in-house counsel, the executive contact.

Protected Health Information (PHI): PHI, sometimes called personal health information, generally refers to demographic information, medical histories, test and laboratory results, mental health conditions, insurance information and other data that a health care professional collects to identify an individual and determine appropriate care. Under the rules of HIPAA and the HITECH Act, covered entities—which include health care providers, insurers and their business associates—are limited in the types of PHI they can collect from individuals, share with other organizations or use in marketing materials. In addition, organizations must provide PHI to patients if requested. See also Business Associate Agreement on page 2.

Release of Liability: See Hold Harmless Agreement on page 4.

Rider: See Endorsement on page 2.

Scope of Work (SOW): A part of the contract that can be contained in the main agreement or included as an exhibit or addendum that specifically outlines

the work to be performed, including specific reports, deliverables, milestones and timelines and other project-specific expectations of the parties. Compensation may also be specified in the SOW or the base contract (referencing that such compensation is for the work contained in the SOW). It is critically important that CBOs understand and include in the SOW exactly what is expected of them and what they can expect from the MCO (e.g., timely referrals, performance reports or data files).

Subsidiary: A subsidiary company is one owned and controlled by another company. The owning company is called the parent company or sometimes a holding company. A subsidiary can be owned by several parent companies or by one parent company, in which case it is known as a “wholly-owned subsidiary.”

Time or Unit-Based Pricing: Traditional Medicaid Long-Term Services and Supports (LTSS) Care Coordination has often compensated CBOs on a unit-based pricing formula. This FFS structure uses a time-based unit and provides a specific payment for every unit of covered services provided. This is usually the easiest and lowest-risk pricing strategy for most types of work. However, there are four important considerations that should be clearly defined in CBO contracts with health care entities:

1. The unit rate must be stated and adequate to cover the CBO’s costs.
2. The activities that constitute billable time (or units) must be clearly defined.
3. A clear understanding of who assesses an individual’s eligibility or need for a service(s) and determines the specific quantity of services (units) authorized.
4. What administrative supplies, services and functions (billing, travel, equipment, training, etc.) may be required, but are not billable on their own.

Withhold: See Financial Risk: Downside Risk on page 3.

This publication was produced by the Aging and Disability Business Institute. Led by the National Association of Area Agencies on Aging (n4a) 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.