

Resource Guide

Contracting Dos and Don'ts

Introduction

Contracting with health care providers and payers can prove challenging for community-based organizations (CBOs). The considerations can be very different from what they may have experienced when working with traditional partners such as government entities and foundations. Many provisions included in CBO contracts with health care entities are driven by legal and regulatory requirements imposed on them as part of their participation in government programs like Medicare or Medicaid, which have strict requirements. Other requirements may be intended to protect the health care organization's interest.

This resource guide explores many of the basic elements CBOs may encounter as they enter into contracting arrangements with health care providers and payers. The goal of this guide is to help CBOs understand, anticipate and prepare for provisions they may encounter when engaging in contract negotiations. It is not the intent of this guide to recommend any one option over another as these decisions require knowledge of the specific facts and circumstances of each CBO and the specific contracting opportunity. As a result, this guide focuses on key, basic contracting provisions that CBOs should ensure are included in their contracting agreements with health care entities—or prompt CBOs to consider why a typical provision might be missing.



Refer to the Aging and Disability Business Institute publication, *Resource Guide: A Lexicon of Contracting Terms*, for definitions of specific terms used in this guide. The guide is available at www.aginganddisabilitybusinessinstitute.org/resources/contracting-toolkit/.

General Contracting Provisions

At a minimum, all CBO contracts with health care entities should include the following universal provisions (some of which may be contained in separate documents):

The Basics

- Identification of all parties involved in the contract, e.g., Integrated Health System (IHS) or Managed Care Organization (MCO) and the CBO/CBOs
- Contacts within both organizations—it is essential to have a primary point of contact (POC)
- Definition of geographic service areas, including the client type, location, volumes and assignment process
- Signatures of all parties
- Time frames related to the work
- Start date and termination provisions, including provisions for early termination (with and without cause) by either party
- Insurance requirements
- Hold harmless, liquidated damages and indemnification provisions
- Nondisclosure Agreement (NDA)
- How and where any disputes will be resolved (legal jurisdiction)

Scope of Work

- Information outlining the work required to be performed and any specific obligations required of all parties involved in the contract will ensure a shared understanding of who is doing what, when, where and how.
- External requirements that are incorporated that are especially relevant to the work (e.g., adherence to state and federal Medicaid and Medicare contracts and related requirements)
- Language describing the nature of the work in detail and clearly defining the relationship as a contractor relationship rather than an employee relationship
- Performance expectations, metrics and measurements of success (or failure)

Information Technology Requirements

- A Business Associate Agreement (BAA)—if Protected Health Information (PHI) is involved
- Information security and compliance expectations of your CBO and its subcontractors, if any
- Data and related information flow, including where data is housed and who has access to it

Billing and Payment

- Financial arrangements, including any value-based/pay-for-performance incentives or penalties
- Billing processes, disputes and resolution protocols

Specific Contracting Provisions

This section is presented from the perspective of a CBO contracting for a coordinating role with downstream service providers such as those participating in managed long-term services and supports (MLTSS) programs in which the CBO might be contracted to perform service/care coordination and manage downstream service providers for an MCO because it covers what may be one of the most complex contracting arrangements CBOs typically consider.

Many contracting situations will involve only pieces of this work and, as a result, CBOs must ensure contracts contain provisions that address their risk and insurance needs.

Contracts (or Scopes of Work) may contain provisions that address areas of specific concern. Examples of provisions often included in Scopes of Work include:

- 1. Responsibilities and workflows:** Ensure that responsibilities, procedures (i.e., who will do what) and workflows are spelled out in the agreement. If there are operational policies your CBO will be expected to follow, be certain you have reviewed and have ongoing access to them. Examples include: Health Insurance Portability and Accountability Act (HIPAA), grievances, appeals, complaint procedures, and exclusion and debarment verification.¹ Although many CBOs already have policies around these requirements, the level of detail, complexity, tracking and reporting may be significantly different in contracts with health care entities. Failure to identify and include workflows in the contract may end up being costly to your CBO.

Specific requirements CBOs should identify include:

- a. Descriptions of which organization is responsible for each aspect of the work to be performed and how information handoffs between the organizations are handled
- b. Licensure or other personnel qualifications (education, experience, training, certifications, etc.) and whether the contract includes an exceptions process
- c. Basic workflows/processes or other information to identify which organization is responsible for what and when, as well as the level of autonomy your agency may have to move forward with your tasks (or what permissions are required prior to proceeding)
- d. Any guidelines (e.g., the MCO's Model of Care) your CBO is required to follow
- e. Data entry and reporting expectations

¹ Exclusion and debarment checks are required for compliance with participation under existing federal or state programs. These checks are intended to verify that individuals performing certain work are not excluded from participation in federally or state-funded health care programs.

- f. What time frames are expected for each step
- g. Information describing who is responsible for recruitment of participants into the program or service
- h. Who performs outreach and communication to members and when such outreach, communication and reporting are performed

HANDS-ON APPLICATION:

Referrals that require a visit to an individual who just entered the hospital for what is expected to be an extended stay can waste time, rather than spend more focused time with the client as the hospital, family and client begin to plan for discharge.

2. Language translation and interpretation services:

When working with members who are non-English speakers, it is important to clearly recognize which party will be responsible for providing translation and interpretation services. Translation and related language services are important to the success of some work but can be expensive. Having the MCO or other payer arrange for their own language translation service may lead to significant cost savings. Another cost-savings measure may be to include language confirming that using family members or others in the household as interpreters is acceptable under the program.

HANDS-ON APPLICATION:

A family member may translate written materials, including assessments, so that the member/client understands what is being communicated to them about their health. Having a family member serve as a translator is a way to engage the family, and helps ensure trust among all involved, including family caregivers. Of course, it is always important to confirm that the client approves of this family member performing the translations. Always check with the payer to confirm that program rules allow for informal translators, especially if the family's proposed translator is a minor.

3. Supervision and oversight responsibilities:

What are your CBO's supervisory and oversight responsibilities? Often, MCOs want to be close to the actual provider. For example, with service coordination, the MCO will have supervisors who will likely expect to interact directly with your agency's service coordinators or other frontline staff. Think through how this impacts your supervisors' caseloads and your agency's culture. If your agency is contracted to manage downstream service provision, is your agency responsible for contracting with that network and handling its claims, as well as ensuring completion and client satisfaction, or will these items be managed by the MCO?

4. Network management: Who is responsible for contracting, payment of, and performance management with downstream providers? Is your CBO managing these claims, and does your CBO have any financial responsibility or risk exposure related to claims payment or financial performance? Answers to these questions will help clarify the role of your agency as a delegated or contracted entity and should be considered carefully.

5. Exclusivity provisions: Many MCOs prefer to contract on an exclusive basis, meaning a contract with them would prohibit contracts with their competitors. Such contracting arrangements are counter to the mission of many CBOs and should therefore be considered cautiously. An alternative model is one in which specific agency staff members are dedicated exclusively to one organization for a given product line (e.g., MLTSS service coordination). Done thoughtfully, this form of exclusivity can benefit both organizations because it streamlines both administration and training and can help your CBO's staff deliver consistently high-quality service as it gets to know the wants and needs of the MCO. To avoid complications with staffing, make sure that the payment arrangements cover the full cost of limiting an employee to a single project or payer. Additionally, because employees of both your CBO and the payer will become very familiar with one another, consider contract provisions that prevent the payer from poaching your best employees.

The volume of work that your CBO has from each MCO should be enough to cover at least one full-time equivalent (FTE) when contracting on an employee-assigned or exclusive basis as the work performed for multiple MCOs cannot be combined. If volume issues with respect to staffing are not addressed under an exclusive basis, staffing problems may arise and could pose a considerable challenge, especially for CBOs in less populated areas. Coverage issues also arise with an FTE model as there is typically little room to absorb temporary workload increases during staff vacations and as a result of staffing attrition. Having a workable agreement with the MCO will help ensure these caseload and coverage issues are addressed. If partial FTEs are allowed, CBOs should ensure that the contract is clear on the payment formulas that are used to determine the appropriate rate of payment for these partial caseloads.

HANDS-ON APPLICATION 1:

John works exclusively with clients of MCO 1 and Jane works exclusively with the clients of MCO 2. If John's caseload only covers 80 percent of his time, does your CBO have other work responsibilities that he can handle to ensure that the agency gets the most productive use of John's time and, potentially, provide John with growth opportunities?

HANDS-ON APPLICATION 2:

MCO 1 – 3.5 FTEs MCO 2 – 2.5 FTEs

Without an exclusivity provision, the 0.5 FTE from MCO 1 and the 0.5 FTE from MCO 2 could be combined to deliver enough work for 1.0 FTE, for a total of 6.0 FTEs. But under an exclusivity provision, the CBO must identify viable options to ensure it doesn't commit to an inefficient staffing structure that could be very costly over time. In this situation, a CBO should consider the following:

1. Negotiate for the payer to retain responsibility for full FTEs. In this case, MCO 1 would fund four FTEs and MCO 2 would fund three FTEs. CBOs should be aware that an MCO is unlikely to commit to doing this for any significant length of time for the same reasons your CBO isn't going to want to do this.

2. Consider the viability of having two part-time employees (e.g., two 0.5 FTEs). While this is not an ideal situation, it may be a viable option for some types of work.
3. Seek to secure contractual assurances that reductions and partial FTEs will be provided, but not on an exclusive basis. In this instance, the employee who handles a 0.5 FTE caseload for each MCO would not be bound to exclusivity rules.

6. **Geographic assignment and boundaries:** Many CBOs, such as Area Agencies on Aging (AAAs), have specific service areas (often a county or group of counties), whereas MCOs may operate in larger areas. This difference in geographic service areas can result in problems with no apparent answers. Having a conversation about geographical service areas may help both parties come to a mutually beneficial agreement on coverage. This may require some leeway or creativity on the part of your CBO's board of directors or county commissioners to allow your employees or subcontractors to cross the historical boundaries to serve assigned participants. If a CBO cannot provide the MCO with an attractive solution, the MCO is likely to look elsewhere.

HANDS-ON APPLICATION:

Your CBO contracts with an MCO to provide care transitions services. How do you handle members who are transitioning from a hospital within your planning and service area, but are transitioning to a setting outside of that area, or vice versa?

Or, under service coordination, what happens if your employee is assigned a member who lives just outside of your planning and service area or the MCO assigns cases based on service coordinators' home addresses and you have service coordinators who live outside of your service area (possibly even across state lines)?

7. Data: Access to accurate data is essential to managing your CBO's business and analyzing your performance. The contract should contain provisions that outline the metrics that will define your CBO's performance and each party's data and reporting obligations. Your CBO should also have a clear understanding of what is going to be measured, how, over what time period, what success will look like, and the data necessary to understand and manage your CBO's performance on an ongoing basis and not simply during the performance review (look-back) period (e.g., quarterly, annually, etc.).

HANDS-ON APPLICATION:

In order to negotiate the best contract terms, your CBO should consider questions such as whose system will be used, how is data captured, analyzed and shared, etc.

8. Hours of operation: Many MCOs expect services to be provided during extended hours that may exceed your CBO's typical hours of operation, including evenings and weekends. Some of these requirements are driven by customer expectations while others are driven by contractual requirements from their contracting partner (state or federal agency). Knowing those expectations and obligations will help your CBO identify appropriate staff coverage. In addition, it is important to know whether your contracting partner has the power to modify these terms without a contract addendum.

9. Call management and response time: There are a few important questions to ask during contract negotiations concerning calls and response times. How are inbound calls handled? Do those calls go to the IHS or MCO's call center, is your agency expected to have a call center, or will the participants be instructed to call your agency's staff directly? What are the call ring time, answer and abandonment rate expectations? Are you expected to record calls and what are the related data capture expectations if you are receiving calls directly?

10. Time frames: What time frame expectations exist on any of the requirements for your CBO? Be very clear on these—what is expected, what are the performance expectations and what happens if your CBO fails to meet those expectations in the designated time frame?

11. Volume, attrition, and referral expectations:

A common concern for CBOs is that the volume of business does not meet expectations. One of the most important elements for establishing a fair price for services is understanding volume expectations.

HANDS-ON APPLICATION:

If your CBO is expecting 100 new participants each month with an attrition rate of 10 per month, it should price its services with an expectation of a net of 90 new enrollees each month. If your CBO receives 10 new referrals each month with an actual attrition of 15 per month, your CBO may fall short of enrollment or revenue targets.

Your CBO's contracting partner may not have information to help gauge expectations, even from historical averages, because it's a new program, service or population or because there is wide fluctuation in the numbers. Either way, this is an important discussion to have with your IHS or MCO contracting partner. Be realistic about your organization's capacity and know that this may be the second most important reason (behind price) to walk away from a prospective contracting opportunity. Also see "Fee Structure Considerations" on page 6 for a discussion of this and the importance of volume in setting a fair price.

12. Cooperation and collaboration: Both parties should commit to an ongoing dialogue to ensure that the relationship is successful and that any issues can be addressed quickly and resolved easily. These conversations should be formally established in the contract to help ensure that a cooperative relationship exists from the start. This may be a formal, regularly scheduled committee or a less formal meeting structure. The point is to establish an ongoing process for intentional dialogue to understand and address issues as well as to work towards quality improvement.

HANDS-ON APPLICATION:

To ensure that the right people are at the table, it may be useful to have a formal management group—or Joint Operations Committee—consisting of key leaders from both parties. In other instances, a more informal hands-on group that meets regularly may be the best approach. In both cases, this group should jointly establish the meeting frequency and the scope of the group's responsibilities. At a minimum, the group should schedule regular, agenda-based meetings with a focus on data-driven performance and quality improvement issues and opportunities.

13. Fee structure considerations: A thorough understanding of all forms of reimbursement and the costs your CBO will incur in the process of delivering services will help your CBO price its services appropriately.

- a. **General:** Important considerations on fee structures include:
 - i. Who pays for start-up and upfront investment costs that are specific to this project (not ongoing operational costs)?²
 - ii. What is the work to be performed under the terms of the contract? Be very specific.
 - iii. What's the expectation around volume? How many individuals are you expected to serve and are there any minimum guarantees?
 - iv. What are the staffing, education, experience, licensure and credentialing expectations?
 - v. What staff will work on this contract and what is the workflow?

- vi. Who provides the technology? If the CBO has to provide its own systems/technology, this should be factored into the fee as well.
- vii. What is the service area? The larger the service area, the more people your CBO is likely to serve and the more distance your staff will cover, so the higher your fee should be.
- viii. What are the reporting and documentation requirements, including billing requirements?
- ix. How will success be measured?

- b. **Uniform fee structure:** Setting a single price, or rate, for a service across a large area can present challenges, especially in large states like California, Texas and New York where there is substantial wage variability by region. This variation needs to be accounted for either directly in the contract or in the amount passed through to downstream providers. Similarly, rural areas often require large amounts of staff travel so mileage reimbursement and reduced caseload sizes should be accounted for in network pricing.
- c. **Fee for service (FFS):** Historically, many health care providers and CBOs have been paid on an FFS basis and some MCOs may be willing to compensate your agency with FFS for some services. For example, meals provided under a home-delivered meals program are often paid for under an FFS arrangement. FFS can provide CBOs with a good way to get started in contracted services work. If your agency is already providing the service, it may also be an easier way to develop your initial pricing models.

² For more on pricing, see the Aging and Disability Business Institute publication, *Resource Guide Pricing CBO Services in a New Health Care Environment*, which is available at www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2018/04/ADBI-resource-guide-Pricing-CBO-Services.pdf.

HANDS-ON APPLICATION:

MCOs and other payers may be reluctant to agree to FFS arrangements in which they are unable to control the volume, especially if higher volumes will result in significantly greater margins for the CBO or its downstream providers. For example, if a retail company contracted with a manufacturer to produce widgets for them and allowed the manufacturer to determine the number of widgets produced under the contract, the retail company will likely end up with more widgets than needed. Under this payment structure, the widget manufacturer will continue to make money by producing and selling widgets to the retail company even if it exceeds the retail company's needs.

HANDS-ON APPLICATION:

You have established a PMPM rate based on an assumption that your service coordinators can manage a 60-member caseload (1:60), meaning your CBO is projecting that it will receive that PMPM (in this example, \$150) times 60 each month ($\$150 \times 60 = \$9,000$ revenue per month for each service coordinator with a 60-person caseload). If the contract requirements specify a ratio of one service coordinator to 50 members (1:50) or the scope of services, poor process or systems, etc., make it impossible for service coordinators to deliver quality results when managing more than 50 active cases, your actual revenue results ($\$150 \times 50 = \$7,500$ revenue per month, per service coordinator) may be inadequate.

- d. **Time or unit-based:** Time or unit-based pricing is often considered the easiest, or lowest risk, pricing strategy for most types of work. When considering a time or unit-based pricing structure, contracts should clearly define three things: a unit rate that covers the CBO's costs, which activities are considered billable time, and who assesses an individual's eligibility or need for service (i.e., the quantity of services authorized as well as the number of units allowed for specific services, and any overall volume limits). If your CBO finds itself negotiating on the use of a unit-based rate, it will be important to ensure that your CBO has conducted time studies and has a solid handle on how those units will align with your CBO's actual work patterns.
- e. **Per Member, Per Month (PMPM):** Many service coordination contracts are priced on a PMPM basis. This means your CBO will be paid a set price per month for each member assigned to you. Under this pricing method (also called capitation), it is critical that your CBO understand exactly what services the MCO has contracted with you to provide within the scope of that fixed monthly payment.
- f. **FTE-based:** Another way to price service coordination is on a full-time equivalent rate basis in which the MCO contracts with your CBO for a set FTE level to perform the work. This pricing model is similar to a PMPM model but may shift some of the risks associated with variation in volume to the MCO. Just as with the PMPM approach, understanding the details behind the rate assumptions is essential to ensure that all costs associated with the work are considered in order to arrive at an appropriate price.

HANDS-ON APPLICATION:

If you are contracting for service coordination, some cost considerations that you should address include: Who is doing the supervisory function? Will the MCO provide basic administrative and call center functions? Who is providing the IT solutions, technology (computers, MiFi, printers, etc.) and if your CBO is responsible, what are the minimum requirements?

- g. **Financial Risk:** To determine what level of risk is right for your CBO, you must be able to accurately assess your CBO's true cost and performance over time. This will require your CBO to evaluate the upside (incentives to your CBO based on good performance) versus downside (withholds or other financial penalties to your CBO for failure to meet specific contract requirements and metrics).³

Downside risk should only be considered if your CBO can honestly and confidently answer “yes” to the questions below. Otherwise, downside risk may put your CBO's fiscal health at risk!

- i. Does your CBO have a long track record?
- ii. Does your CBO have an extremely good understanding of your cost structures?
- iii. Does your CBO have significant experience with the population (or a very similar population) that you're proposing to serve?
- iv. Does your CBO have control over the process from end-to-end and, if not, do you have safeguards in place to ensure that your team is able to perform to your expectations?

Most CBOs should start new projects with either no risk or only upside risk. In this scenario, your CBO should base its decision on the financial feasibility of any contract on your CBO's ability to reasonably predict that it can cover its costs, plus a reasonable margin with the base contract rate. Do not count on the upside bonus.



Conclusion

The critical point in contracting with health care entities is to understand what is being asked of your CBO, what it is capable of performing, and ensuring that your CBO is being adequately compensated for the work it is expected to perform. Contracts should provide all parties with a clear roadmap of roles and responsibilities along the way.

For more information on contracting, see the “Evaluate Contracts” resource category on the Aging and Disability Business Institute's website at www.aginganddisabilitybusinessinstitute.org/resources/category/evaluate-contracts.

When in doubt, ask questions. Still in doubt? Seek the advice of an experienced colleague, legal or financial advisor or professional consultant. The National Association of Area Agencies on Aging provides consulting services to support its members as they navigate the health care contracting arena. Information is available at www.aginganddisabilitybusinessinstitute.org/about/contact-us/consultant-guide.

³ For more on pricing, see the Aging and Disability Business Institute publication *Resource Guide Pricing CBO Services in a New Health Care Environment*, which is available at <https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2018/04/ADBI-resource-guide-Pricing-CBO-Services.pdf>.

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