CONTRACTING FOR VALUE BASED PAYMENT

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Department of Health Care Finance

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INTRODUCTION

- Value-Based Purchasing (VBP) is an approach that ties payment to the quality and efficiency of healthcare services delivered.
- This resource provides contracting tools to support value-based payment arrangements, beginning with a description of the components of legally enforceable contracts and the legal terms generally found in such contracts. The materials describe key legal considerations for arrangements between providers, which will assist providers in identifying and navigating potential legal issues. Recommendations are offered on how to address legal risks through the purchase of insurance, managing contracts throughout the contracting lifecycle, and negotiating contracts with other organizations.

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WHAT IS A CONTRACT?

WHAT IS A CONTRACT?

- A contract is a specific type of relationship that is enforceable by law. By entering into the agreement, the parties to a contract bind themselves to each other.
- Some contracts last for a long time (such as a one-time purchase), whereas others could span several years (such as a lease).
- Contracts can cover a wide range of circumstances, both in business settings and personal relationships. Business contracts are varied and can cover all aspects of a business, including those with patients, employees, payors, vendors and business partners.
- Agreements must be entered into voluntarily, and the purpose of the agreement must not be illegal or contrary to public policy.

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WHAT ARE THE LEGAL ELEMENTS OF AN ENFORCEABLE CONTRACT?

- A contract is an agreement between two parties that creates an obligation to perform (or not perform) a particular duty.

- A legally enforceable contract requires:

1. An Offer (I'll mow your lawn, if you pay me $30)
2. An Acceptance (You've got a deal)
3. Consideration (The value received and given)

- Mutual assent: a meeting of the minds.

- If you are not careful, a contract may not be enforceable when you want it to be and may be enforceable when you don't want it to be.

- Working with a qualified attorney ensures that a contract works how you intend.

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WHAT IS AN "OFFER" UNDER CONTRACT LAW?

- An offer is an expression of willingness to contract on certain terms, made with the intention that it shall become binding as soon as it is accepted by the person to whom it is addressed.
- An offer must be voluntary and consensual.
- Whether an offer has been made is not based on a party's real intentions, but whether a reasonable person would have perceived there to have been an offer (i.e., objective test).

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WHAT IS "ACCEPTANCE" UNDER CONTRACT LAW?

≫An acceptance is an expression of asset to the terms of an offer.

- Does the offeree's conduct communicate agreement?
- Acceptance can be expressed or implied.

≫Some offers contain limitations on how and when the offer may be accepted (e.g., a deadline for responding the offer), and the acceptance must conform to those limitations.

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WHAT IS "CONSIDERATION" UNDER CONTRACT LAW?

- Consideration is something of legal value that must be given by each party in exchange for what was promised or given by the other.

- A contract must have bargained-for exchange, where there is some quid pro quo given for the promise by the promisee.

- Consideration cannot be a:
  - Gift
  - Illusory promise (e.g., an indefinite promise, suggesting that performance is optional.)
  - Pre-existing duty (by law or otherwise)

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WHEN IS A CONTRACT UNENFORCEABLE?

- If the scope of contract is illegal, then the contract (or portion of it) may be declared void.

- A contract may be unenforceable if it violates the following:
  - Anti-trust laws
  - Anti-Kickback Act
  - False Claims Act
  - HIPAA

- A contract may also not be enforced if it is “unconscionable”
  - Unconscionable means that no rational person would make that contract, and no fair or honest person would accept the contract terms.
  - These include contracts that are grossly unfair or against public policy, typically arising when a business tricks a vulnerable person into agreeing to unfair contracts.

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WHAT ARE THE BENEFITS OF AN ENFORCEABLE CONTRACT?

- Engage in a transaction with enforceable legal obligations
- Clarify expectations (e.g., hourly wage, scope of services, reimbursement rate)
- Set parameters for how parties should resolve disputes
- Consider the risks and benefits of a potential arrangement

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ORAL VS. WRITTEN CONTRACTS

- Contracts may generally be written or oral - both types may be binding.
- Restrictions and concerns associated with oral contracts:
  - Higher risk for disagreement - difficult to enforce as agreed upon terms are unclear.
  - Statute of Frauds - common law concept that prevents enforcement of oral contracts relating to (1) the sale of land, (2) the sale of goods with a value in excess of a low dollar amount (e.g., $500), or (3) contracts that are unable to be fully performed within one year.
- *Avoid oral contracts!*

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SOURCE OF CONTRACT LAW

- Although there is some federal law applicable to contracts, it is limited to federal concerns, such as the regulation of interstate commerce (e.g., Uniform Commercial Code (UCC)) or to contracts entered into by the Federal Government (e.g., the Federal Acquisition Regulations).
- Because contracts are within the realm of state law, most contracts cases are decided by state courts.
- There are 50 bodies of different state contract law in the United States. Each state (except Louisiana), has adopted the common law of England as its basic legal system.
  - Louisiana adopted the civilian system, in the form of the French Code Napoleon during the short period it was a French possession.

WHAT ARE EXAMPLES OF TYPES OF CONTRACTS?

- Employment Agreements
- Professional Services Agreements
- Vendor Agreements
- Confidentiality Agreements
- Business Association Agreements
- Affiliation Agreements (e.g., Co-Location)
- Managed Care Contracts (i.e., Provider Participation Agreements)
- IPA/ACO/CIN Participation Agreements

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MINI SELF ASSESSMENT

Photo by Glenn Carstens-Peters on Unsplash

Knowledge	1	2	3	4	5	6	7	8	9	10
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Reflect & Connect:

What do you think your organization may look like 5 -10 years from now if you incorporate and build upon these concepts?

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ANATOMY OF A CONTRACT

HOW ARE CONTRACTS TYPICALLY STRUCTURED?

- Identification Parties: Who are the parties?
- Recitals (the “whereas” statements): What is the background?
- Scope of Services: What are the obligations of the party?
- Payment: What is the payment obligations of the other party?
- Term: What is the length of the contract?
- Termination: How the contract terminate?
- Default/Breach/Cure: What happens if a party breaches their duties?
- Dispute Resolution: How will disputes be handled?
- Choice of Laws: Which state’s law applies to disputes?
- Venue/Jurisdiction: Where will disputes be held?

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IDENTIFICATION OF THE PARTIES

- Contracts generally start of by identifying the parties

  This Agreement is entered into by and between Company, Inc. and Organization (individually, the "Party" and collectively, the "Parties") to set forth the objectives, understandings and agreements between the Parties.

- Consider who is legally bound pursuant to the contract
  - Does it identify the correct parties?
  - Does it identify the parties by the correct legal name?
  - Avoid the creation of third-party rights.

- Parties may be individuals and/or business entities

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SCOPE OF SERVICES

- Should clearly identify and describe the scope of services furnished by one party to the other
- Be specific and avoid ambiguity. Is there an expectation regarding:
  - Standards of care
  - Quality of goods
  - Staff qualifications
  - Provision of goods/services in accordance with certain policies and procedures
  - Timeline for furnishing services
- Consider adding warranties and representations meant to accompany performance of the contract.
  - A warranty is defined as an express or implied promise that something in furtherance of the contract is guaranteed by one of the contracting parties.
  - For example, it is common for providers to represent that they are qualified and are not excluded or debarred from government lists.

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TERM OF CONTRACT

- The term is a period of time in which a contract is in force. A well-defined time period will have a start date and often a start time, as well as an end date and often an end time. The times and dates should be determinable without any doubt, vagueness or ambiguity.
  - Example: This contract is effective from execution until January 1, 2016.
  - Consider whether law mandates a minimum term (e.g., one year to fit within an Anti-Kickback Statute safe harbor)
- Consider whether the contract should provide for automatic renewal absent notice of termination
- From a contracting perspective, how long do you want to be able to rely on the other party's obligations?
  - If it is a short term, then either party will be relieved of performance in a relatively short period of time. That could make the contract less valuable to one or both of the parties. If it is a long period of time, then that could be more valuable.
  - For instance, in an employment contract with a clinician, you will be making a large investment in her or her of time and mentoring. In exchange, you may want the term of the contract to be sufficiently long so that you get a return on the investment. If it is too short, then the clinician may take what they learn from you and go somewhere else before you have a chance to recoup the investment.

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TERMINATION

Examples of Grounds for Termination:

- Convenience (also known as a “without cause” termination)
- Breach (*e.g.*, a party’s failure to compensate the other party in accordance with the schedule/rates, as defined in the agreement)
  - Consider opportunity to “cure” (i.e., an opportunity for a party to correct its potentially material breach.)
- Bankruptcy of either party
- Failure to maintain required insurance
- Failure to maintain certain qualifications/licensure
- Exclusion from federal health care programs

- In reviewing termination provisions, ask what the circumstances should be in which your organization will be able to exit the contract.

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DISPUTE RESOLUTION

- A contract should use a graduated, step-by-step dispute resolution process
  - **Informal negotiation:** Parties agree to negotiate resolution in good faith in a timely manner.
  - **Mediation**: A method of dispute resolution in which a third party seeks to mediate the dispute by facilitating a voluntary resolution.
  - **Arbitration:** A method of dispute resolution involving one or more neutral third parties who are usually agreed to by the disputing parties and whose decision is binding.
  - **Judicial remedies:** The parties agree to settle their dispute through litigation in state or federal court.

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CHOICE OF LAW / SAMPLE CLAUSE

- Choice of Law is implicated where there is a dispute regarding which state law should be applied to resolve the dispute between the parties.
- This usually occurs when the parties are from different states, or activities relevant to the case occurred in different states. For a state's laws to be applicable to a particular case, that state must be in some way involved in the matter surrounding the disputed contract.
- Choice of law can be very important because different states' laws can differ in ways that may impact the outcome of your case.
- Sample clause: "This Agreement shall be governed by and construed in accordance with the laws of the District of Columbia, without giving effect to its conflicts of law principles."

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VENUE / FORUM SELECTION / SAMPLE CLAUSE

- Venue is the place for arbitration or trial, usually because the place has some connection with the events that gave rise to the dispute.
- A forum selection clause allows parties to establish where (in and sometimes, which court) arbitration or trial will occur if there is a dispute.
- Sample clause: “The Parties agree that venue for any suit, action or proceeding with respect to this Agreement will lie exclusively in any court of competent jurisdiction located in the District of Columbia.”

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MINI SELF ASSESSMENT

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LIMITATIONS ON ARRANGEMENTS WITH OTHER PROVIDERS

FEDERAL ANTI-KICKBACK STATUTE

Anti-Kickback Statute (AKS) - 42 U.S.C. § 1320a-7b(b)

- The Anti-Kickback Statute is an intent-based criminal statute that prohibits remuneration, whether monetary or in-kind, in exchange for patient referrals under Federal health care programs.
- Remuneration specifically includes kickbacks, bribes, and rebates made directly or indirectly, overtly or covertly, or in cash or in kind.
- Prohibits persons and entities from knowingly or willingly:
  - Soliciting or receiving remuneration directly or indirectly, in cash or in kind
  - To induce patient referrals or the purchase or lease of equipment, goods or services
  - Payable in whole or in part by a Federal health care program
- There is no "specific intent" requirement to violate the law:
  - "With respect to violations of this section, a person need not have actual knowledge of this section or specific intent to commit a violation of this section."

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FEDERAL ANTI-KICKBACK STATUTE

Violations of the statute can result in:

- Criminal liability
  - Felony conviction – up to $100K fine, imprisonment up to 10 years, or both
- Civil penalties under the Civil Monetary Penalties Law
  - Up to $100K fine and damages of 3x amount of remuneration
- False Claims Act (FCA) liability
  - When a violation of the antikickback statute occurs, the resulting claims are false or fraudulent under the False Claims Act
- Administrative proceedings
  - Suspension or exclusion from participating in federal health care programs

SAFE HARBORS UNDER THE ANTI-KICKBACK STATUTE

- Safe Harbors are arrangements determined by Congress / HHS to present a low risk of fraud and abuse.
- If safe harbor requirements are met, the arrangement does not violate the law
- Compliance with any safe harbor is voluntary.

- Safe Harbors have been established for:
  - Discounted arrangements
  - Space and equipment leases
  - Employment arrangements
  - Practitioner recruitment in underserved areas
  - Personal services and management contracts

- Referral arrangements for specialty services
- Waiver of co-insurance and deductible amounts
- Sale of practice and investment interests
- Group purchasing organizations
- Discounts to managed care organizations
- Federally Qualified Health Center donations
- Federally Qualified Health Centers and Medicare Advantage Organizations
- Free or Discounted Local Transportation

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REFERRAL ARRANGEMENTS - EXAMPLE

- *Example*: A primary care provider (the “referring provider”) agrees to refer patients to a behavioral health provider (the “referral provider”).
- The purpose of the referral agreement is to coordinate scheduling, assure accessibility of services, document how patient health information will be exchanged for treatment purposes.
  - The referral provider should retain control and liability over the services it provides. The contract should state that the referral provider is responsible for billing and collecting all payments from appropriate third-party payors or funding sources. The referral provider’s policies / procedures / standards govern the services.
  - The referring provider should not be liable for any damages incurred by the referral provider in furnishing services to the referred patients or arising from any acts or omissions in connection with the provision of such referral services.

REFERRAL ARRANGEMENTS – SAMPLE PROVISION

- To comply with the federal Anti-Kickback statute, the contract should include a provision that states:

  - *Nothing in the Referral Agreement requires, is intended to require, or provides payment or benefit of any kind (directly or indirectly), for the referral of individuals or business to either party by the other party. Neither provider shall (i) require or encourage their professionals to refer patients to one another (or to any other entity or person); or (ii) track such referrals for purposes relating to setting the compensation of their professionals.*

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PROFESSIONAL SERVICES AGREEMENTS / SAMPLE TERMS

- *Example*: A behavioral health provider leases the services of a psychiatrist from a private practice to provide services at the behavioral health provider's site on its behalf.
- The behavioral health provider is responsible for billing and collecting from third parties / patients and retains all revenue secured for services provided by contracted practitioners.
- Contracted practitioners provide services in accordance with the provider's applicable health care and personnel policies, procedures and standards (e.g., clinical guidelines, productivity and QA standards, standards of conduct, record-keeping), and its grant requirements (if applicable).
- The contract should contain a provision addressing the qualifications of practitioner and the behavioral health provider's oversight of the contracted practitioners. For example:
  - Contracted practitioners must meet the behavioral health provider's professional standards and qualifications (e.g., maintains necessary and appropriate licensure)
  - Contracted practitioner shall not be excluded from participating in federal health care programs
  - The behavioral health provider retains the right to terminate the contract or to request / require removal, suspension and/or replacement of any contracted practitioner who lacks qualifications, is non-compliant with policies and procedures, provides sub-standard care or otherwise performs unsatisfactorily,

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PROFESSIONAL SERVICES AGREEMENTS

- Professional services agreements should be structured to comply with the Anti-Kickback Statute Personal Services and Management Contracts Safe Harbor (42 C.F.R. § 1001.952(d). The safe harbor requires:
  - A written agreement signed by parties
  - A term of at least one year
  - A payment amount or methodology set in advance
  - Compensation that is reasonable, fair market value and determined through arm's length negotiations
  - A written agreement that specifies the exact services required to be performed
  - Compensation that must not be determined in manner that takes into account volume or value of referrals
  - The services performed must not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law
  - The Aggregate services must not exceed those which are reasonably necessary to accomplish the commercially reasonable business purpose

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PROFESSIONAL SERVICES AGREEMENTS

- If the professional services agreement contains outcome-based payments, then to comply with the safe harbor such payments must:
  - Reward successfully achieving an outcome measure, which are regularly monitored and assessed for impact on quality of care, and periodically assessed to ensure remuneration is consistent with fair market value.
  - Exclude any payments made directly or indirectly by certain specified entities, relate solely to the achievement of internal cost savings for the principal, or are based solely on patient satisfaction or patient convenience measures
  - Be based on legitimate outcome measures and have benchmarks that are used to quantify the quality of patient care; costs or expenditures or both.
  - The methodology for determining the aggregate compensation (including any outcomes-based payments) paid between or among the parties over the term of the agreement is: set in advance; commercially reasonable; consistent with fair market value; and not determined in a manner that directly takes into account the volume or value of any referrals or business otherwise generated between the parties.
  - The agreement must neither limit any party's ability to make decisions in their patients' best interest nor induce any party to reduce or limit medically necessary items or services.
  - The principal must have policies and procedures to promptly address and correct identified material performance failures or material deficiencies in quality of care resulting from the outcomes-based payment arrangement.

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SPACE AND EQUIPMENT LEASES

- If a health care provider leases space or equipment from another health care provider, the contract should be structured to comply with the Anti-Kickback Statute Personal Services and Management Contracts Space and Equipment Safe Harbors (42 C.F.R. § 1001.952(b) and (c).
- These safe harbors generally require:
  - Written agreement signed by parties
  - A term of at least one year
  - All premises/equipment tare specified in the written agreement
  - The agreement specifies exact schedule (if access is periodic)
  - Payment amounts that are set in advance
  - Compensation that is reasonable, fair market value, and determined through arm's length negotiations
  - Compensation that is not be determined in a manner that takes into account volume or value of referrals

EXCLUDED PROVIDERS

- If a provider employs or contracts with an individual that the provider knows or should have known has been excluded from a federal health care program, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services may impose significant civil monetary penalties on the provider, and similarly exclude such provider from participation in federal health care programs on a go-forward basis.
- These penalties could apply if the excluded individual participates in any way in the furnishing of federal health care program items or services, including, but not limited to, providing direct patient care or through the provision of administrative/management services.
- Providers should be careful that they do not enter into service agreements with individuals or entities excluded from participation in federal health care programs (*e.g.,* Medicare, Medicaid, Federal Grant Programs).

Practice Pointer

- Include a representation and warranty in the contract that the other party is not excluded from federal health care programs.

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EXCLUDED PROVIDERS – SAMPLE PROVISION

Individual/Entity hereby represents and warrants that Individual/Entity is not and at no time has been convicted of any criminal offense related to health care nor has been debarred, excluded, or otherwise ineligible for participation in any federal or state government health care program, including Medicare and Medicaid.

- *Further, Individual/Entity represents and warrants that no proceedings or investigations are currently pending or to Individual/Entity's knowledge threatened by any federal or state agency seeking to exclude Individual/Entity from such programs or to sanction Individual/Entity for any violation of any rule or regulation of such programs.*
- *Individual/Entity hereby agrees to immediately notify [Provider] in writing of any threatened, proposed, or actual conviction or exclusion from any federal or state funded health care program, including Medicare and Medicaid, or any investigation that could lead to a conviction or exclusion.*
- *In the event that Individual/Entity is convicted of any criminal offense related to health care or is excluded from participation in any federal or state funded health care program during the term of this Agreement, or if at any time after the effective date of this Agreement it is determined that Individual/Entity is in breach of this provision, this Agreement shall, as of the effective date of such conviction, exclusion, or breach, automatically terminate.*
- *Individual/Entity shall indemnify and hold harmless Provider against all actions, claims, demands, and liabilities, and against all loss, damage, costs, and expenses, including reasonable attorneys' fees, arising directly or indirectly, out of any violation of this provision of this Agreement by [Provider], or due to the exclusion of Individual/Entity from a federal or state funded health care program, including Medicare or Medicaid.*

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MINI SELF ASSESSMENT

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ANTITRUST AND OTHER LEGAL CONSIDERATIONS

ANTITRUST LEGAL CONSIDERATIONS

Legal Authorities

- Sherman Act, Section 1
  - Prohibits every contract, combination, or conspiracy in restraint of trade.
  - Supreme Court limits the prohibition to only “unreasonable” restraints.
  - For joint ventures, courts apply the “Rule of Reason” to determine whether the restraint likely harms competition by facilitating an anticompetitive increase in prices or reduction in outcome, quality, or innovation, or on the other hand, whether the agreement is ancillary (reasonably necessary) to achieve substantial integration likely to generate efficiencies and other procompetitive benefits.

- Federal Agency Guidance
  - Statements of Antitrust Enforcement Policy in Health Care (1996) (Withdrawn by DOJ on February 3, 2023 and by FTC on July 14, 2023.
  - Guidelines for Collaborations Among Competitors (2000)

ANTITRUST LEGAL CONSIDERATIONS

Joint Ventures and Competitor Collaborations

- Agreements among actual or potential competitors can enhance competition by reducing costs or permitting the introduction of new services or other innovations through the pooling of resources.
- In applying the Rule of Reason, federal agencies will examine nature and purpose of joint venture (JV), looking at business purpose and types of restraints involved.
  - Does the JV reduce or eliminate competition among the participants in the joint venture?
  - Does the contract bar the JV participants from opening a new site in the service area or expanding services?
- From an antitrust perspective, the key question is whether any restraints are necessary for a legitimate joint venture to operate effectively and create efficiencies.
- JVs that allocate markets, territories, or customers require careful assessment to ensure that they are reasonably related to, and reasonably necessary for the operation of, a legitimate joint venture or collaboration, and the benefits of such restraints outweigh the potential harm.
- Note: Collaborations that involve competitors sharing non-public competitively sensitive information related to current or future strategic plans will raise more antitrust risks than collaborations that involve sharing of historical business plans and aggregated data.

Guidelines for Collaborations Among Competitors (2000)

ANTITRUST LEGAL CONSIDERATIONS

Collaboration Guideline Safety Zones

- Safety Zones Generally
  - Collaborations in a safety zone are presumed lawful; collaborations outside safety zone are not necessarily unlawful.
- Safety Zone for Competitor Collaborations
  - Absent extraordinary circumstances, the Agencies will not challenge a competitor collaboration when the ***market shares of the collaboration and its participants collectively account for no more than twenty percent of each relevant market*** in which competition may be affected.
  - The safety zone, however, does not apply to agreements that are per se illegal, or that would be challenged without a detailed market analysis, or to competitor collaborations to which a merger analysis is applied.
- Safety Zone for Research and Development Competition Analyzed in Terms of Innovation Markets

Guidelines for Collaborations Among Competitors (2000)

CONFIDENTIAL AND PROPRIETARY INFORMATION

- What is the nature of the relationship?
  - Employer/Employee
  - Vendor
  - Affiliation Partner
  - Consultant
- What information is being protected?
- Does the provider have intellectual property that it will be sharing/wants to protect?
- Will there be a Non-Disclosure/Confidentiality Agreement or confidentiality provisions in the agreement?

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CONFIDENTIALITY AND PROPRIETARY INFORMATION - SAMPLE PROVISION

- 1. Non-Disclosure
- A. I will hold all Confidential Information in confidence and will not disclose, use, copy, publish, summarize, or remove from the premises of Company any Confidential Information, except (a) as a necessary to carry out my assigned responsibilities as a Company employee, and (b) after termination of my employment, only as specifically authorized in writing by an officer of Company. However, I shall not be obligated under this paragraph with respect to information I can document is or becomes readily publicly available without restriction through no fault of mine. "Confidential Information" shall mean all information related to any aspect of the business of Company which is either information not known by actual or potential competitors of Company or is proprietary information of Company, whether of a technical nature or otherwise. Confidential Information includes inventions, disclosures, processes, systems, methods, formulae, devices, patents, patent applications, trademarks, intellectual properties, instruments, materials, products, patterns, compilations, programs, techniques, sequences, designs, research or development activities and plans, specifications, computer programs, source codes, costs of production, prices or other financial data, volume of sales, promotional methods, marketing plans, lists of names or classes of customers or personnel, lists of suppliers, business plans, business opportunities or financial statements.
- B. I will safeguard and keep confidential the proprietary information of customers, vendors, consultants and other parties with which Company does business to the same extent as if it were Confidential Information. I will not, during my employment with Company or otherwise, use or disclose to Company any confidential, trade secret or other proprietary information or material of any previous employer or other person, and I will not bring onto Company's premises any unpublished document or any other property belonging to any former employer without the written consent of that former employer.

- https://www.sec.gov/Archives/edgar/data/1084201/000119312506147033/dex47.htm

DISCLOSURES OF PROTECTED HEALTH INFORMATION

Covered Entities (CEs) are permitted to use and/or disclose PHI:

1. To the individual
2. Treatment, payment, and health care operations, as permitted by and in compliance with 45 CFR § 164.506
3. Incident to an otherwise permissible or required use or disclosure
4. Pursuant to and in compliance with the authorization of individual
5. Pursuant to an agreement under, or as otherwise permitted, by:
   - 45 CFR §164.510: Uses and disclosures requiring an opportunity for the individual to agree or to object
6. As permitted by and in compliance with:
   - 45 CFR § 164.512: Uses and disclosures for which an authorization or opportunity to agree or object is not required
   - 45 CFR § 164.514 (e): Limited data set
   - 45 CFR § 164.514 (f): Fundraising communications
   - 45 CFR § 164.514 (g): Uses and disclosures for underwriting and related purposes

See 45 CFR §164.502(a)(1)

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DISCLOSURES OF PROTECTED HEALTH INFORMATION

- Treatment: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

45 CFR §164.501

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DISCLOSURES OF PROTECTED HEALTH INFORMATION

- Payment: Encompasses the various activities of health care providers to obtain payment or be reimbursed for their services.
- Examples:
  - Determining eligibility/coverage under plan and adjudicating claims;
  - Billing/collection activities/reviewing health care services for medical necessity, coverage, justification of charges;
  - Utilization review activities

45 CFR §164.501

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DISCLOSURES OF PROTECTED HEALTH INFORMATION

- Health Care Operations: Certain administrative, financial, legal, and quality improvement activities of a CE that are necessary to run its business/support core functions of treatment and payment, including:
  - Conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, and case management and care coordination;
  - Reviewing the competence or qualifications of health care professionals, evaluating provider and health plan performance, training health care and non-health care professionals, accreditation, certification, licensing, or credentialing activities;
  - Business planning and development, such as conducting cost-management and planning analyses related to managing and operating the entity.

45 CFR §164.501

DISCLOSURES OF PROTECTED HEALTH INFORMATION

- Notice. Any use or disclosure of PHI for treatment, payment, or health care operations must be consistent with the CE's notice of privacy practices. A CE is required to provide the individual with adequate notice of its privacy practices, including the uses or disclosures the CE may make of the individual's information and the individual's rights with respect to that information

45 CFR §164.520(b)(ii)(A)

DISCLOSURES OF PROTECTED HEALTH INFORMATION

Reasonable Safeguards

- CEs must have in place appropriate administrative, technical, and physical safeguards that protect against uses and disclosures not permitted by the Privacy Rule and that limit incidental uses or disclosures
- In establishing reasonable safeguards, CEs can consider:
  - Size and the nature of its business
  - Nature of the protected health information
  - Potential risks to patients' privacy
  - Potential effects on patient
  - Financial and administrative burden of implementing particular safeguards

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DISCLOSURES OF PROTECTED HEALTH INFORMATION

Minimum Necessary Standard

- When using, disclosing, or requesting PHI, a CE must make reasonable efforts to limit PHI to the minimum amount necessary to accomplish the intended purposes of the use, disclosure, or request
- Does not apply to:
  - Disclosures to or requests by a health care provider for treatment
  - Uses or disclosures made to the individual
  - Uses or disclosures made pursuant to an authorization
  - Disclosures to HHS, use and disclosures required by law or required for compliance with applicable requirements
- CEs must develop policies and procedures that reasonably limit the disclosures of, and requests for, PHI for payment and health care operations to the minimum necessary
- CEs are also required to develop role-based access policies and procedures that limit which members of its workforce may have access to PHI for treatment, payment, and health care operations, based on those who need access to the information to do their jobs

45 CFR §164.502(b)(2)

BUSINESS ASSOCIATE AGREEMENTS

Covered Entities (CEs) must obtain satisfactory assurances from Business Associates (BAs) that BAs will appropriately safeguard the PHI it creates or receives on behalf of CE

- Business Associate agreements must:
  - (i) Establish the permitted and required uses and disclosures of PHI by the BA. The contract may not authorize the BA to use or further disclose the information in a manner that would violate the requirements of this subpart, if done by the CE, except that:
    - (A) The contract may permit the BA to use and disclose PHI for the proper management and administration of the BA, as provided in paragraph (e)(4) of this section; and
    - (B) The contract may permit the BA to provide data aggregation services relating to the health care operations of the CE.
  - (ii) Provide that the BA will:
    - (A) Not use or further disclose the information other than as permitted or required by the contract or as required by law;
    - (B) Use appropriate safeguards and comply, where applicable, with subpart C of this part with respect to electronic PHI, to prevent use or disclosure of the information other than as provided for by its contract;
    - (C) Report to the CE any use or disclosure of the information not provided for by its contract of which it becomes aware, including breaches of unsecured PHI as required by §164.410;
    - (D) In accordance with §164.502(e)(1)(ii), ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the BA agree to the same restrictions and conditions that apply to the BA with respect to such information;
    - (E) Make available PHI in accordance with §164.524;
    - (F) Make available PHI for amendment and incorporate any amendments to PHI in accordance with §164.526;
    - (G) Make available the information required to provide an accounting of disclosures in accordance with §164.528;
    - (H) To the extent the BA is to carry out a CE's obligation under this subpart, comply with the requirements of this subpart that apply to the CE in the performance of such obligation.
    - (I) Make its internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the BA on behalf of, the CE available to the Secretary for purposes of determining the CE's compliance with this subpart; and
    - (J) At termination of the contract, if feasible, return or destroy all PHI received from, or created or received by the BA on behalf of, the CE that the BA still maintains in any form and retain no copies of such information or, if such return or destruction is not feasible, extend the protections of the contract to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
  - (iii) Authorize termination of the contract by the CE, if the CE determines that the BA has violated a material term of the contract.

45 CFR §164.504(e)(2)

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BUSINESS ASSOCIATE AGREEMENTS – SAMPLE PROVISIONS

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- Training & Resources

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Business Associate Contracts

SAMPLE BUSINESS ASSOCIATE AGREEMENT PROVISIONS
(Published January 25, 2013)

Introduction

A "business associate" is a person or entity, other than a member of the workforce of a covered entity, who performs functions or activities on behalf of, or provides certain services to, a covered entity that involve access by the business associate to protected health information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate. The HIPAA Rules generally require that covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard protected health information. The business associate contract also serves to clarify and limit, as appropriate, the permissible uses and disclosures of protected health information by the business associate, based on the relationship between the parties and the activities or services being performed by the business associate. A business associate may use or disclose protected health information only as permitted or required by its business associate contract or as required by law. A business associate is directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule.

A written contract between a covered entity and a business associate must: (1) establish the permitted and required uses and disclosures of protected health information by the business associate; (2) provide that the business associate will not use or further disclose the information other than as

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

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PART 2 AND DISCLOSURES: GENERAL RULES

- 42 CFR Part 2 (“Part 2”) is intended to ensure that a patient receiving treatment for a SUD in a Part 2 Program does not face adverse consequences in relation to issues such as criminal proceedings and domestic proceedings such as those related to child custody, divorce or employment.
- Part 2 protects the confidentiality of SUD patient records by restricting the circumstances under which Part 2 Programs or other lawful holders can disclose such records.
- Part 2 Programs are federally assisted programs. In general, Part 2 Programs are prohibited from disclosing any information that would identify a person as having or having had a SUD unless that person provides written consent.
- Part 2 specifies a set of requirements for consent forms, including but not limited to the name of the patient, the names of individuals/entities that are permitted to disclose or receive patient identifying information, the amount and kind of the information being disclosed, and the purpose of the disclosure (see §2.31).
- In addition to Part 2, other privacy laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) have been enacted. HIPAA generally permits the disclosure of protected health information for certain purposes without patient authorization, including treatment, payment, or health care operations.

https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf

PART 2 AND QUALIFIED SERVICE ORGANIZATIONS: GENERAL RULES

» 42 CFR § 2.11: Qualified service organization (QSO) means an individual or entity who:

1. Provides services to a Part 2 Program, and
2. Has entered into a written agreement (QSOA) with a Part 2 Program under which that individual or entity:
   - Acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the Part 2 Program, it is fully bound by Part 2; and
   - If necessary, will resist in judicial proceedings any efforts to obtain access to patient identifying information related to substance use disorder diagnosis, treatment, or referral for treatment except as permitted by Part 2.

MINI SELF ASSESSMENT

Photo by Glenn Carstens-Peters on Unsplash

Knowledge	1	2	3	4	5	6	7	8	9	10
Comfortability	1	2	3	4	5	6	7	8	9	10
Confidence	1	2	3	4	5	6	7	8	9	10

Reflect & Connect:

What do you think your organization may look like 5 -10 years from now if you incorporate and build upon these concepts?

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RISK MANAGEMENT

TYPES OF RISKS

- **Clinical** — is the possibility of an adverse outcome resulting from clinical investigation, treatment or patient care. Clinical risk can include medical staff credentialing, misdiagnosis, surgical procedures, administration of medication, treatment, research issues, experimental procedures, informed consent issues, HIV testing and disclosure, medical records, other areas that affect patient care and service.
- **Operational** — possibility of loss or damage to buildings, office equipment (including management information systems), personal property, and vehicles, machinery malfunctions, harm to staff and patients, as well as the possibility of theft or dishonesty.
- **Legal** — quality of care issues, statutory responsibilities of employers to employees (state workers' compensation), liabilities pursuant to contract, and tort liabilities under which the provider can be sued for alleged injuries to patients, employees, and others.
- **Regulatory** — Federal, state, and local regulations; compliance issues. Note: An effective corporate compliance program designed to satisfy Office of Inspector General guidelines is a critical risk management tool.
- **Human Resources** — risks that relate to the provider's workforce throughout the lifecycle of the employment relationship, from recruitment and retention to termination.
- **Technology** — risk associated with the use of technology throughout the organization, from vulnerabilities to the confidentiality, integrity, and availability of data to risk related to the organization not keeping up with technological advancements in the health care industry.
- **Financial** — maintaining solvency, grants management issues, maintaining appropriate documentation of cost reasonableness, allocability, and allowability, appropriate fiscal management standards and cash drawdown policies, officer and employee bonding, reserves, and investments.

TYPES OF RISK LIABILITY CONTROL

- **Risk Avoidance –** Risk avoidance eliminates the source of a risk by discontinuing a certain practice or service. Risks deemed too hazardous for the provider to assume should be eliminated or contracted out. Explore other options that do not involve retaining the risk. The "down- side" to risk avoidance is that discontinuation of certain services may not always be feasible or desired. Examples: discontinuing a provider's evening hours of operations because of security concerns and the expenses associated with hiring a security guard; eliminating the direct provision of certain non-mandatory services.
- **Loss Control or Risk Reduction –** This method minimizes the potential for risk through a reduction in frequency of exposure to risk or a reduction in its severity. Determine what risks are susceptible to being reduced through instruction and training. Examples: Developing a program of equipment inspection, testing, and maintenance may serve to reduce the risk associated with equipment failure; instituting a process for promptly addressing building code violations; training medical staff to recognize and respond to allergic reactions to medication.
- **Separation –** Risk separation reduces losses of irreplaceable items, such as donor lists, by making copies and keeping items stored in separate locations and keeping items such as important computer files and software in safe, locked locations.
- **Retention –** Risk retention involves a strategic decision to bear a risk. With risk retention, a provider is making an informed decision to "gamble" by retaining a risk because of little opportunity for a downside or because the downside itself is bearable. Example: A provider uses an old van to run errands or transport volunteers. The van may be worth only $500 but runs well. Instead of purchasing collision insurance, the provider could decide to retain the risk of collision loss and accept the potential loss of a $500 van. (Note: while the provider may wish to assume the risk with respect to collision loss in such a situation, it should still obtain sufficient insurance with respect to bodily harm and injury.)
- **Transfer of risk –** A provider may be able to transfer certain risks to another party by insurance or by contract to a subsidiary or related organization. With the other entity taking on the risky activity, the risk may be transferred away from the original source. Example: where appropriate, the use of contracted physicians for highly specialized (high risk) services rather than employees; contracting for janitorial staff as opposed to directly hiring such staff in order to avoid the risk of waste management and disposal.

INSURANCE COVERAGE CHECKLIST

- Conduct a risk assessment to determine coverage needs
- Define what is covered and review coverage exclusions
- Shop for insurance and
- Understand the nature of current policies and coverage related matters (e.g., retention amounts, exclusions, occurrence vs. claims made, policies, indemnification and hold harmless obligations).

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INSURANCE COVERAGE RISK ASSESSMENT

- Identify the liability risks (i.e., exposures to loss) associated with the provider's operation, including both the likelihood of incurring a loss and the potential size of such loss in a dollar amount;
- Review the existence and effectiveness of established policies, protocols, and appropriate safeguards that identify and reduce or avoid such risks; and
- Assess whether such risks have been transferred to a third party contractually.

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DEFINE WHAT IS COVERED AND REVIEW COVERAGE EXCLUSIONS

- Be extremely thorough about reading and understanding policies, including all of the “fine print”
- Pay particular attention to the description of the insured risks and the scope of all applicable exclusions or limitations (which identify certain risks which will not be covered by the policy)
- Diligently review and negotiate insurance policy terms to ensure that the policy provides overage for the actual losses/damages incurred and covered by the policy
- Ensure that the policy provides the provider with the right to have a legal defense against claims provided by, or at a minimum paid for by, the insurer.

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SHOP FOR INSURANCE COVERAGE

- Read (and understand) the entire policy before buying it, paying particular attention to deductibles, exclusions, and any other coverage limitations.
  - Remember, an insurance company that balks at providing the policy ahead of time is probably not a company with which the provider should do business.
- Assess the insurer's financial stability by researching applicable "ratings," such as Standard and Poors®, which measures the financial strength of an insurer. The Standard and Poors® scale "grades" insurers from AAA (extremely strong) to CC (extremely weak).
- Ensure the accuracy and thoroughness of its entries on insurance application form(s).
  - Any material misrepresentation made in an application can be used by an insurer as grounds to retroactively rescind a policy or otherwise deny coverage for a particular claim.

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UNDERSTAND THE NATURE OF YOUR POLICIES

- Your insurance policies are contracts between you and the insurer – make sure you know what is in your contract.
- What is your premium?
- What are your limits and deductibles/retention amounts?
- What does the insurance company believe it's covering?
- Understanding terminology in your policies e.g., retention amounts, exclusions, limits, conditions, endorsements, occurrence vs. claims made policies, indemnification, and hold harmless obligations.

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TYPES OF INSURANCE COVERAGE

- Professional Liability (Malpractice, Errors & Omissions)
- General Liability/Property Insurance
- Workers' Compensation/Employer Liability Insurance
- Fidelity/Bond Insurance
- Directors and Officers Insurance
- Employment Practices Liability Insurance
- Commercial Vehicle Insurance
- Business Interruption Insurance
- Umbrella Insurance
- Cyber Liability Insurance

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PROFESSIONAL LIABILITY (MALPRACTICE, ERRORS & OMISSIONS)

- Professional liability insurance (also commonly referred to as malpractice or errors and omissions insurance) protects against liabilities that arise from an error or omission in the performance of professional services by a licensed professional (*e.g.*, physicians, lawyers, architects).
- In the case of health care providers, professional liability coverage is procured to protect the provider and its practitioners against claims arising from the services of its employed and/or contracted professionals that provide services on behalf of the provider.
- While the cost of professional liability insurance can vary greatly among states due to the legal environment in each state, the cost usually is quite substantial.

GENERAL LIABILITY AND PROPERTY INSURANCE

- General liability insurance is a basic coverage used to protect against claims of property damage and personal (bodily) injury, *e.g.*, "slip and fall" coverage, which occur on the provider's premises or otherwise are a result of the provider's operations.
- Most general liability policies will include coverage for related medical costs incurred by an injured party, as well as other compensatory and general damages; however, punitive damages (*i.e.*, damages intended as punishment for intentional/reckless acts) and special damages are generally excluded from coverage.
- Such policies also commonly cover liabilities arising from libel, slander, infringement of privacy or intellectual property infringement.
- Property insurance covers the risk of financial loss arising from damage and/or destruction of the provider's buildings, equipment and supplies (or other real or personal property) from fire, storms, and similar events. A provider would use this insurance to cover the costs of repairing and/or replacing the affected property upon the occurrence of a triggering event.
- Similar to most liability insurance policies, general liability and property insurance policies customarily exclude coverage for the following types of losses:
  - Intentional injuries
  - Criminal fines and penalties
  - Punitive/special damages
- General liability and property damage insurance can frequently be purchased together as a single policy.

PRIVACY/CYBER LIABILITY/DATA BREACH INSURANCE

- Providers collect large amounts of data on the patients they serve, including financial information (credit card numbers, bank account information, etc.) and protected health information (medical records, appointment calendars, etc.).
- Loss of this confidential information or unintended release of this information to the public or other unauthorized third parties can cause serious problems for an organization.
- The costs of data breaches can include paying for credit monitoring for a large number of patients, defending breach of privacy lawsuits, payment of significant HIPAA fines.
- These costs can be overwhelming and debilitating to a provider's overall program.
- Providers should consider purchase of this kind of data breach insurance to protect against the losses associated with risk.

MINI SELF ASSESSMENT

Photo by Glenn Carstens-Peters on Unsplash

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Reflect & Connect:

What do you think your organization may look like 5 -10 years from now if you incorporate and build upon these concepts?

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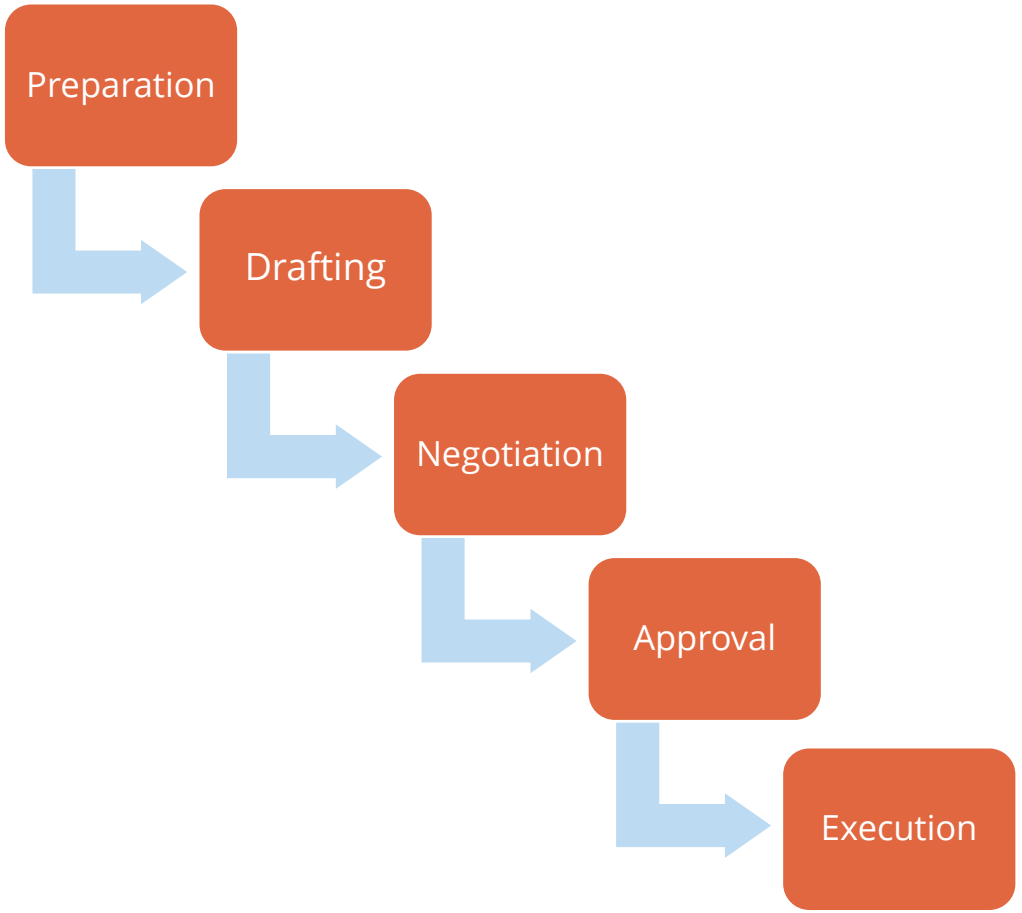
CONTRACT MANAGEMENT ACROSS THE CONTRACTING LIFECYCLE

CONTRACTING LIFECYCLE



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CONTRACT LIFECYCLE: PREPARATION PHASE

- Is there a term sheet?
- What is the purpose the contract?
- Why is the contract necessary?
- What are the goals of the contract?
- What is your understanding of the terms of the deal?
- Are there deal breakers?
- Is this a procurement?
- Is there a contract template?
- Who will negotiate the contract?

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CONTRACT LIFECYCLE: DRAFTING

- Who will draft the contract? Will it be the provider or the vendor?
- Does the contract accurately describe the arrangement that the provider is contemplating?
- Does the contract align with the provider's internal policies and procedures?
- What are the regulatory/legal requirements that will apply to the contract?
- Are there any outstanding issues that need to be discussed?

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CONTRACT TERM CHECKLIST

- **Parties.** Who are the parties to the contract? Are they identified correctly?
- **Effective Date.** What is the effective date of the contract? Is it the date the contract is signed or another date?
- **Recitals.** Does the contract accurately describe the background of the parties and their interest in the agreement?
- **Scope of Work/ Services/Obligations.** Does the contract describe that which is being contracted for?
- **Term & Termination.** What is the term of the contract? Are there termination clauses for convenience and cause? What are the notice requirements? Is there an evergreen clause?

CONTRACT LIFECYCLE: DRAFTING

CONTRACT TERM CHECKLIST

- **Default/Breach/Cure.** What is the cure period for a breach? Do some defaults/breaches result in automatic termination?
- **Financial Terms.** What are the financial terms of the contract? What are the requirements around invoicing/billing? What fees and penalties are assessed
- **Representations & Warranties.** What is each party promising? Can the provider meet those promises?
- **Insurance & Indemnification.** What are the insurance requirements in the contract? What does the contract say about indemnification?
- **Privacy & Security of Patient Health Information.** Is patient health information being exchanged and/or does the other party have access to patient information?
- **Fraud & Abuse Provisions.** Does the contract involve giving or receiving remuneration in exchange for something paid for by a government health care program?

CONTRACT TERM CHECKLIST

- **Dispute Resolution.** Does the contract speak to arbitration, mediation or litigation as a mechanism to resolve disputes?
- **Notice.** What does the contract say about notice – is the information correct?
- **Choice of laws.** Does the contract say that the law of the jurisdiction of the provider will control?
- **Venue/jurisdiction.** What about the venue for litigation? Is it the jurisdiction of the provider?

CONTRACT LIFECYCLE: NEGOTIATION

- Who will negotiate the contract?
- Will the provider use legal counsel?
- How will the contract be negotiated?
- What are the deal breakers?
- What are considered commercially reasonable terms?
- Are you negotiating with a community partner or are you negotiating with a for-profit entity?
- What is your negotiating power?

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CONTRACT LIFECYCLE: APPROVAL

- Who needs to approve the contract?
- Are there dollar thresholds that require Board approval?
- Who approves vs. who signs?
- Does the provider delegate signature authority beyond the CEO/Executive Director?
- What do the Bylaws say?
- Is there an audit trail for all of the approvals?

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CONTRACT LIFECYCLE: EXECUTION

- Who signs the contracts/binds on behalf of the provider?
- Does the provider use electronic processes for signature?
- Does the provider's policies contemplate the use of electronic signatures?
- Does the provider collect fully executed copies of contracts?

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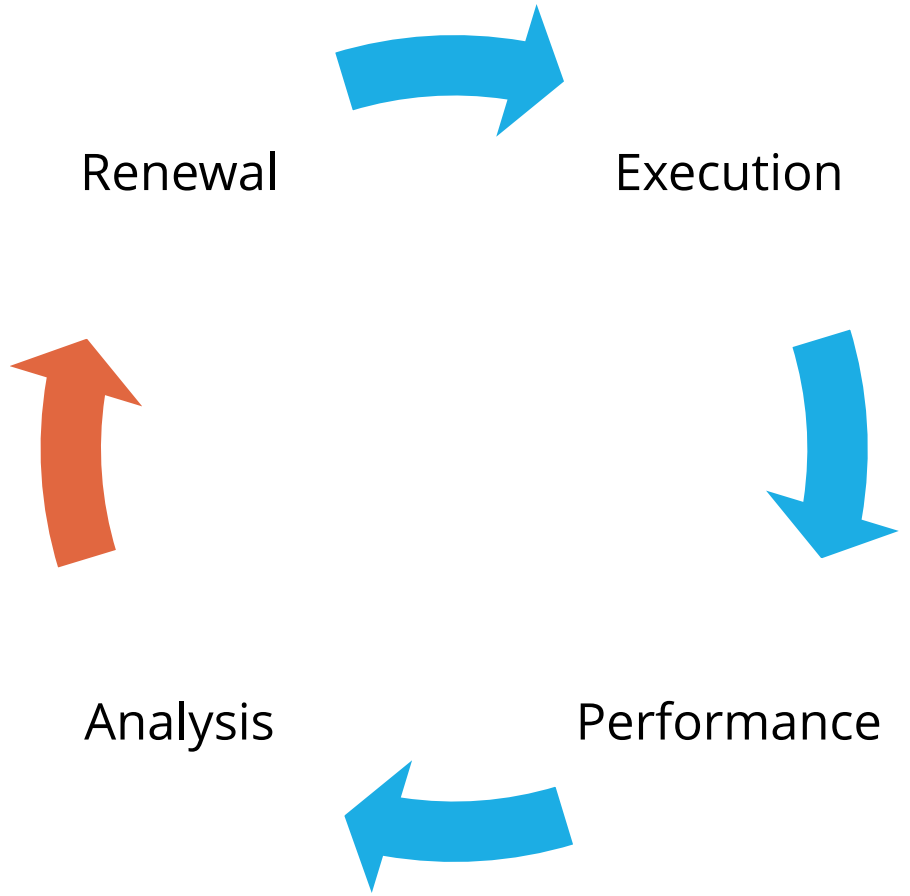
CONTRACT MANAGEMENT



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CONTRACT MANAGEMENT: PERFORMANCE

- Who owns the contract?
- Who manages compliance?
- Who is tracking the term, notice requirements for renewals and expiration?
- Who manages contract performance, deliverables?

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CONTRACT MANAGEMENT: ANALYSIS

- At what time interval will the provider review how the contract is working?
- How does the provider get feedback from staff about how the contract is serving (or not serving) the best interests of the provider?
- How does the provider review changes in the internal/external environment that might affect the contract?

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CONTRACT MANAGEMENT: RENEWAL

- Does the contract have an evergreen provision or must the provider take proactive steps to renew the contract?
- What decisionmakers are involved in determining whether a renewal is in the best interest of the provider?
- What is the timeframe for renewal?
- If the contract will not be renewed, are there any closeout obligations?

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MINI SELF ASSESSMENT

Photo by Glenn Carstens-Peters on Unsplash

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Reflect & Connect:

What do you think your organization may look like 5 -10 years from now if you incorporate and build upon these concepts?

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HOW TO READ A CONTRACT

HOW TO READ A CONTRACT

1. Start at the end.

- Locate the exhibits, attachments, and addenda at the end of the agreement.
- Identify the services (*e.g.*, scope of vendor's services) and applicable fees.
- Confirm the scope of services is correct and that fees have been described.

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HOW TO READ A CONTRACT

2. **Go back to the beginning and review the introductory paragraph on the contract.**
   - Confirm that it correctly states your legal name, type of legal entity, and mailing address.
   - Confirm the Effective Date or Start Date, if stated.
3. **Skip the "definitions" section (for now).**
   - Any capitalized term in the contract will always be a defined term (though the term will not always have been defined in the definitions section!).

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HOW TO READ A CONTRACT

4. **Ensure you have a complete contract.**
   - Look for either a table of contents or a checklist after the signature page that lists out each of the included exhibits, appendices, and addenda that have been (or should be) included.
   - Alternatively, look for references in bold or underline in the body of the agreement to exhibits, appendices, and addenda.
   - Confirm that all exhibits, appendices, and addenda listed or cited in the contract have been included.

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HOW TO READ A CONTRACT

5. Evaluate the contract terms

- ❑ Does the contract include favorable provisions for key terms?
- ❑ Can you operationalize all of the applicable requirements?
- ❑ Are responsibilities for each party clearly stated and all terms defined?
- ❑ Have you reviewed any policies, procedures, and documents referenced in the contract?
- ❑ Does signing the contract reflect sound business judgment?

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HOW TO READ A CONTRACT

6. Identify and *Prioritize* Issues

- Categorize each issue as follows:
  - **Red**: Critical issues that without addressing you cannot afford to proceed because the risks (not just financial) are unacceptable for the organization.
  - **Yellow**: Significant issues that should be addressed before proceeding because they create undesirable risks for the organization.
  - **Green**: Issues that ideally would be addressed prior to proceeding to reduce potential risks.

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MINI SELF ASSESSMENT

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Reflect & Connect:

What do you think your organization may look like 5 -10 years from now if you incorporate and build upon these concepts?

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NEGOTIATING A CONTRACT

NEGOTIATION: PREPARATION PHASE

- Contracts are voluntary agreements rather than one imposed on the parties by arbitration or judicial process.
- If you can't reach agreement, you may walk away, or find someone else to contract with.
- In the preparation phase, you should strive to understand your interests as well as the interests of the opposing party
- A party that understands its interests and the interests of the opposing party has an advantage in achieving its objectives.
- Is your organization able to negotiate from a position of strength?
  - If not, what can you do to strengthen your position?"

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NEGOTIATION: PREPARATION PHASE

- Assessing **leverage** is an essential component of any negotiation because it determines if one party has greater power in making demands of the other.
- For example, when negotiating with an MCO:
  - Regulatory leverage:
    - Is the MCO required by law or regulation to include you in the network?
    - Is the MCO required to pay you at a specific rate or level?
  - Market leverage:
    - Are there other providers in the market offering the same services as you?
    - Can the MCO "afford" to leave you out of the network?
  - Timing leverage:
    - Is the MCO creating a provider network from scratch?

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Self-Assessment

- Identify and assess your organization's strengths (and weaknesses)
  - Clinical and administrative capacity
  - Infrastructure
  - Existing relationships with community providers/agencies/vendors
- Identify potential limitations (or opportunities) by virtue of the organization's licensure and/or grant funding

NEGOTIATION: PREPARATION PHASE

Assess the other party

- What is the past performance of the other party? Gather information about past experience.

Managed Care Organization (MCO)

- Did the MCO meet its payment obligations on time?
- Was the number of denied claims excessive?
- Did the MCO give the provider a role in the development of policies, such as utilization review?
- Was the MCO responsive to the provider's authorization requests?

IT Vendor

- What is the vendor's experience in your industry and community?
- Is the vendor well reviewed?
- Are the vendor's rates consistent with fair market value?

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NEGOTIATION: PREPARATION PHASE

- Competing on value means that you are in a position to make demands of the other party because you offer something of additional value to the other party as compared to other providers in the marketplace
- For example, what value do you bring to an MCO?
  - Do you provide access to a target population of the MCO?
  - Do you offer savings to the MCO through the reduction of ER visits or preventable hospitalizations?
  - Do you offer integrated physical and behavioral health care that reduces the incidence of illness?
  - Are you willing to incur some downside financial risk that would otherwise fall upon the MCO?

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NEGOTIATION: EVALUATE THE CONTRACT

- A thorough review of any draft contract from the business, operational, clinical, and legal perspectives is essential
  - A significant number of contract issues arise after a contract is signed because someone who ought to have been part of the review process was not consulted.
    - Can occur when someone further down the chain is not consulted and a contract term is not practical or creates a huge burden
    - Can also occur when a person higher up the chain is not consulted and some aspect of the contract creates some kind of liability or risk.
- Many vendors and providers offer a “standard contract”; do not assume that the provider must accept this contract wholesale!

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NEGOTIATION: EVALUATE THE CONTRACT

1. **Set a timeframe for review**
2. **Create a contract review team**
   - Establish “point person” to review / draft the contract
   - Assign areas of contract review to team members based on expertise
3. **Assemble documents**
   - Draft desired agreement or obtain entire proposed contract, if applicable, including all referenced and incorporated documents
   - Obtain other documents necessary to understand legal obligations

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NEGOTIATION: EVALUATE THE CONTRACT

4. Create a term sheet:

- Anticipated scope of work
- Applicable requirements/expectations
- Appropriate fee/compensation (consider fair market value analysis)
- Applicable legal considerations (e.g., HIPAA, Anti-Kickback Statute, False Claims Act)
- Desired causes for termination
- Other desired business terms

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NEGOTIATION: EVALUATE THE CONTRACT

5. Create an organized process to methodically analyze, discuss, and evaluate the terms of the contract.

- Identify contracting leaders.
- Leave ample time to analyze the contract.
- Avoid rushing the process.

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6. Use a Checklist to Review the Contract

Checklists can promote consistent contract reviews and ensuring that issues are not inadvertently overlooked.

- Understand what all provisions mean
- Identify provisions that disadvantage the provider from a financial, clinical, operational, or legal perspective
- Ensure that responsibilities are clearly stated, and all terms are unambiguously defined
- Ensure all policies, procedures and documents referenced in the contract are included in or accompany the contract (or can be easily and directly obtained)
- Ensure that any references to statutes, codes, regulations, etc. are precise
- Ensure that the contract and all requirements and responsibilities comply with all applicable Federal and State laws, regulations and policies
- Ensure contract reflects sound business judgment

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NEGOTIATION: EVALUATE THE CONTRACT

7. Identify Issues for Negotiation

- What liabilities are created by particular provisions (or terms within provisions)?
- What modifications are critical – terms without which the provider cannot afford to proceed because the risks (not just financial) are unacceptably high?
- How can modifications be drafted so that they are fair to both parties and do not frustrate fundamental objectives of the parties? In other words, can the parties find common ground, and preferably, a "win-win" situation?

NEGOTIATING THE CONTRACT: DEVELOP YOUR STRATEGY

- It is not enough to simply present your terms and proposed modifications to the other party
- Instead, your organization should develop an individualized negotiation strategy, including the following:
  - A list of the organization's objectives and priorities for the contract
  - Development of a list of deal points / critical elements for negotiation
  - Formation of the framework for negotiations using the objectives, priorities, and deal points
  - Establishment of a bottom line for withdrawal (i.e., when do you say "no"?)

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NEGOTIATING THE CONTRACT: COMMON ERRORS

- A common error is bargaining over positions
  - Occurs when one or both parties get stuck in ensuring that they win on their positions, regardless of whether the overall goal is attained
  - Parties take extreme positions in the expectation that they will have room to bargain down
  - Results in a loss of focus on underlying concerns
- Focus on underlying interests:
  - Respond with questions, rather than statements, and respond specifically to the other entity's concerns
  - Develop options for mutual gain and generate a variety of possibilities before deciding what to do
  - Look for zones of agreement and areas of overlap, emphasizing the importance of maintaining an ongoing relationship
  - Base terms on objective standards

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NEGOTIATING THE CONTRACT: OBJECTIVE STANDARDS

Examples of objective standards:

- Market value
- Precedent
- Scientific judgment
- Professional standards
- Efficiency
- Costs
- What a court would decide
- Equal treatment
- Moral standards
- Tradition
- Reciprocity

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NEGOTIATING THE CONTRACT: COMMON OBSTACLES TO GENERATING OPTIONS

» Common obstacles to generating options:

1. Premature judgment
2. Searching for the single answer
3. The assumption of a fixed pie
4. Thinking that “solving their problem is their problem”

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NEGOTIATING THE CONTRACT: WHEN TO WALK AWAY

- When to walk away: set a “bottom line” based on factors including
  - the importance of the contract to your organization
  - the extent to which the contract embodies the organization’s goals and objectives
- It may be best to walk away if the organization does not trust the other entity or if the two are not a good “fit”
- The organization must walk away from any contract that does not pass legal muster in its final form (for example, it includes provisions that are inconsistent with or contrary to specific legal requirements)

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MINI SELF ASSESSMENT

Photo by Glenn Carstens-Peters on Unsplash

Knowledge	1	2	3	4	5	6	7	8	9	10
Comfortability	1	2	3	4	5	6	7	8	9	10
Confidence	1	2	3	4	5	6	7	8	9	10

Reflect & Connect:

What do you think your organization may look like 5 -10 years from now if you incorporate and build upon these concepts?

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