Growth and Development: Capitalize on New Business Opportunities
Wednesday, July 31, 2019

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Webinar begins…
[Erica Lindquist] Good afternoon. Thank you for joining today's webinar, Growth and Development: Capitalize on New Business Opportunities.

This webinar is presented through the business acumen center, a part of the business facility organization grant managed by the administration on community living. After today's session, you can find the PowerPoint recording of this webinar along with all the webinars at the website. There will be time for Q&A at the end of the presentation. These enter your question in the Q&A box. Today's presenters include Brian O'Reilly, CPA and partner with BKB and Koy Dever, also a principal at BKD. They will be talking together to discuss strategies and resources on facilities organizations used to stabilize your organization and capitalize on new business opportunities. I will have the conversation over to Brian.

[Brian O'Reilly] Thank you. Just to mention, Cody and myself, both are in the New York office of BKD. I worked in our IDD and behavioral health division dealing with reimbursement reporting compliance issues here. Cody works in our healthcare division working with our managed-care companies and various healthcare providers. Today, we will talk about what CBO's should be doing to prepare their organization for the changing environment we live in. Including looking at whether or not having your organization being ready for change. This includes utilizing some of the various strategies of environmental scans and analysis that is included in a CBS business acumen toolkit. We'll talk about assessing and monitoring physical health, how your organizations financial readiness for change is coming. And then we will finish with a section on contracting 101 which will focus on issues involved in contracting with managed-care companies as well as others. Disruptor and disrupt the, these are the new buzzwords in the business environment today. And which is saying that we are in a state of constant change and in this day and age, and organization cannot simply stand still. You can do the same thing you been doing for the last few years. Stated another way, change is inevitable, and this is true even for CBO's.

[Brian O'Reilly continues] One of the things is unanticipated disruptors to an organization can be life-threatening. There are a couple of good examples in the business community. One of them is Kodak and one is Blockbuster. Kodak actually had designed the first digital camera back in 1975. But, it did when disrupt its sales of its film and developing business which was its core business. The results of this is not a surprised ending to anybody who doesn't own a Kodak digital camera. They went into bankruptcy because they didn't see the future coming and they didn't anticipate and prepare for it. And as a result, disruption came to them. Like Blockbuster, also another organization that used to be everywhere and now is nowhere. Actually, had the opportunity to buy b Netflix for about $50 million. Netflix now is worth about $20 billion. Again, the management there didn't see what was coming down the road.

They didn't try to anticipate what could be coming and therefore they didn’t see the possibility of a changing environment which Netflix did see, and Netflix is a very successful company and Blockbuster is gone. CBO's need to do this. They need to prepare for the anticipated and the unanticipated. Yet look at what the future may bring and how you will address that. Now, there are a lot of disruptions for CBO's. Also, a lot of disruptors possible for CBO's. You can change your funding stream, changes in funding methodologies, changes in program models. Here in New York, we had the situation where most organizations operated and performed MSC in the IDD business. And they change data and change it over to conflict free care organizations to get business away from these agencies. This problem was this eliminated about $21 million worth of surpluses in the system. Agencies had to deal with this and the good one started anticipating what I'm going to do about the fact I'm using my simplex? How my making this up?

[Brian O’Reilly] How do I handle these expenses that were being covered by this program? They took a situation of a disruption and they had to deal with it. So, everybody has to look at these kinds of disruptions from the kind of standpoint. You also have changes in payers, also we will have the implementation of value-based payments. This is an evolving thing in this community. It is going to be regularly moving forward to that and that will change how your paid. We'll talk about that in the 2nd. Ultimately, will be moving to managed-care which is in various different stages throughout the country. Now, remembering the lessons from Kodak and Netflix, organization should not just be looking at how they can react or address being disruptive, but trying to be the disruptors. Again, you shouldn’t be trying to sit still, you need to be moving yourself forward. And that means you need to be looking for new business opportunities, looking for potential collaborative partners, in order to be able to change what you're doing, to expand what you're doing to grow the business. All this takes a lot of time and effort, but it is something organizations need to be dedicating themselves to.

Disruption requires organizations to understand and focus on things like the payer sources and their impacts on their program. Especially if you have a new pair, yet to figure out what that is going to mean and what you need to do with that pair. Also, in order to be able to operate that business, dealing with the variability of dealing with people, you need to be able to analyze how much it costs for you to provide these services. So, we'll talk about that you need to understand your current financial position. Disruption puts enormous pressure on her organizations’ finances. He being the disruptor or the disruptee. You need to make sure you are in a position to be capable weathering those changes is a come down the road. You also need to look at your value proposition and add to market yourself. You want to know what you are good at and how you can sell that into the environment. In short, you should be doing the following -- talking about looking at environmental scans, the factors that are affecting our business. And, looking at your analysis which is looking at your strengths, your weaknesses, what opportunities you have in the threats in relation to the environmental scan. The first up is looking at your potential payers.

[Brian O'Reilly continues] CBO's have an array of potential revenue streams including Medicaid, state and local government organizations, private insurance, health systems, sometimes they are the subcontractor, private pay individuals, third-party contracts and the emerging areas of ACO's and managed care organizations. Generally, revenue stream is considered a good thing because being reliant on a single source can limit with the organization can do and where they can spread your dollars. The downside of having the rest beside revenue streams as multiple pairs come with complexity, different billings, documentation requirements, submission of forms, technology systems. So, all of that creates complexity. You have the potential of delays and payments that can result in having multiple pairs and multiple roles stop this can result in a increase -- nobody, no organization especially CBO's cannot afford bad debts. You need to understand the reimbursement structure you being paid under which includes a number of things. It can be fee-for-service, contract which could be expense reimbursed or it could be a pay for performance kind of situation. Capitation if we get to a risk-based system, value-based payments as I said is an evolving area but will be present as part of reimbursement structure.

[Brian O'Reilly continues] This will be in the near future. The interesting thing about this is each of these reimbursement structure impacts how your organization should manage your programs. For example, if you are paid for services provided, you'll focus on making sure you are providing as many services as you can. If you are in a cost reimbursed program, you will need to monitor how and what you're spending and making sure you're spending in the right categories. If you will be moving into value-based payments, you will need to focus on the outcomes of the services, more often they need to be focusing on providing a service. So, each of these things will impact how you operate your program and run your business.

As I said, in order to operate a business successfully, you need to understand how much it cost for you to do your service, provide your services, rather. This requires you to break it down into the cost into its component. You need to break it down into a cost. individual served. The first thing is to break that into the key concepts of separating six variable cost because you need to understand what increases will change with volume as opposed to what items I'm just fixed with and won't change. And, the older accounting joke is we will make it up in volume. It is actually a true statement. You actually can grow yourself out of losses that it takes, looking at these two components and budgeting based on those two components to be able do that. You also have to factor in acuity levels. This is probably the greatest challenge. How do we factor in the cost of different types of individuals and with different needs on what we are doing services to people?

And, there is not a lot of good ways of doing this because there's also not a lot of good acuity measurement tools. We've been implementing here in New York something called the comprehensive assessment system. It is, they're hoping it will provide more in-depth information when it gets is fully implemented. This will be a direct link between acuity and what the direct needs of service providers for effective reimbursement. We haven't gotten there yet and we are inventing it, so I imagine around the

country we don't have anything that is readily available at this moment the provides the pure acuity level be used to determine how much will be spending depending on the client we are serving.

[Brian O'Reilly continues] From a standpoint, if we are operating multiple sites, we can try to benchmark cited inside and we have ideas relative to the different acuity levels of the different population, we can start getting some ideas on a greater basis, theoretically, this is where the state agency should provide this kind of analysis to provide what you are getting reimbursed relative to the services that you are providing and what kind of acuity levels you are serving. Again, if ever larger volume that can translate into an understanding of how much it will take for you to serve different levels. And, you have to break it up into your direct care and clinical staff and support functions including program administration, I see occupancy course which means more than your building depreciation, and includes utilities and housekeeping, security, anything related to the building, stop and, make sure we talk about administration, we're not just talking about agency administration.

We are talking about program administration and also factoring in any other any cause. And, this will vary but this has to be taken into consideration when we are trying to figure out if we are going into a new service we haven't done. What are the unique costs that are different? And, as I said, disruption puts pressures on your finances. And as I said, disruption puts pressure on your finances. So, we need to first, assess before we start planning on our expansion or where we will move into on how is our financial viability? There are number ways of assessing financial viability? We look at profitability, the bottom line PNO. We look at liquidity. We have resources to pay her bills? Look at our financial statements? What does it saying about us? There is also knew liquidity disclosures and the statements which may be saying something about how her ability is to meet our expenditures. And, cash versus accrual. I would say you can go to business on the cast spacious and the accrual basis. You can go out of business on the cash basis faster than the accrual basis. Focusing on cash management, cash reserves is key to assessing and moving an organization forward in a state of change.

[Brian O'Reilly continues] Now, drilling it down from there, looking at profitability. There are a lot of ways of looking at this, he looked bottom line surplus loss. When we look at this, we are including contributions and income and other income. The problem with this is the unpredictable nature of these items. It is interesting that baccalaureate the recession and 2008, the agencies I dealt with which had the most difficulty were the ones that were well endowed. They had gotten used to living on the resources that came to them because of the fact they had all these resources. And, therefore, when the world changed back and 2008, and the investment in --income went into the toilet, and contributions slow or dry up, those organizations struggle the most where the organizations that live to hand to mouth, they continue to exist as nothing it happened in 2008.
It is great that if you have these things, it seems to be the better way to have contributions and investment income. More importantly, look at it from an operating surplus loss which strips out these non-operated items

and look to see how we are doing, are surplus loss from operating our programs. Very often, these are losses on an overall basis. A lot of places get used to living on other things that are funding them. In this day and age, organizations need to focus on what programs they are using and they need to determine, whether or not, their mission-critical and, whether or not, they can afford to fund the deficit if they are running a deficit.

[Brian O'Reilly continues] And, if not, and how will the one that deficit? It requires organizations to not only focus on bottom line surplus loss but looked at operating surplus loss. You should look at profitability under a multiyear basis. It is not a one-year thing. A one year loss is not necessarily a problem. Sometimes, we are places that plan offices. It sounds like a crazy concept, but we have cost reimbursed systems that encourage that to a certain extent. When your loss is not necessarily a problem . A multi-year loss, especially if you have trends downward, we could be in a situation where we are still in a surplus situation. If our surpluses wingling down, that is a problem. That needs to be assessed. Looking at profit margin, this is net income as a percentage of revenue. It is a simple way of looking at what is our variability and what happens to us? And, I use a 3% number as a bare minimum. We should be writing this as a profit margin, obviously got, the larger the better. We did the analysis of the IDD providers in New York and found out that on an overall basis, the profit margin was only 1.6% over the last 5 years.

This whole industry here is running on a very thin margin and in my mind, they are running too close for comfort. Now, moving on to liquidity and cash reserve measures, there are a lot of different ratios. Some of the ones I've listed here, the current ratio, the primary reserve days, days and reserve, these are areas trying to look at liquidity and whether or not we have the resources to pay our current bills. And, a lot of our ratios, looking on a current basis, as I said before, you can run out business on an accrual basis or you can run out of business faster on a cash basis and you can on accrual basis. The concept of focusing on your, these liquidity measures is important. They should be in a regular dashboard you are looking at either on whatever financial reporting periods you are doing, monthly or quarterly. So, if you know how you're doing in tracing that over a trend over a period of time. As I keep harping on cash reserves, one of the most important things, unrestricted cash on hand.

How much do we have? What are our lines of credit? At a minimum, we should have three months of operations so if you have some kind of disruptor that causes us to not that the cash flows from the programs we operate, so we can survive. So, it is very important, I remember an organization that had their CFO, a large organization. He believed his primary responsibility was managing the relationships with the bank, to make sure his lines of credit were strong. So, that is how important this is to an organizations physical health. And, you should also be doing what is probably most organizations are doing. Looking at your

[Brian O'Reilly continues] ongoing financial reporting. Doing your basics, your budget versus actual. Making sure you are managing within

your budget, checking your financial health in order to be able to make sure you are using the ratios we just talked about but also other ratios. Looking at how you do your cost allocations. Cost allocations, if they are not focused on, maybe giving you misinformation about how you are doing in a particular program. Therefore, you should focus on how you're doing your allocations in order to be able to determine how you are doing, how a program is operating or whether or not it is a problem. You should be tracking some key statistics in dashboards as I refer to which is designed to liquidity ratios I talked about.

you should be doing a dashboard on things such as staffing, utilization, outcome measures. You won't have these things in a regular reporting to use so you have information on how you are doing at your fingertips. Having a regular report that gives it to you in a very simplified format that can be presented to you, to key management positions that are in charge of monitoring these programs you operate. As well as providing that information to the board of directors. Finally, you want to develop your value proposition and marketing your service. You want to know what you're good at but you need to know more than that. You need to factor in what your mission is.

As I said before, a lot of places will run programs because it fits her mission and, I understand that. But, you want to figure out whether that can be afforded by the organization and how you will pay for it if it does run at an operating loss. An organization mission is first and foremost when an organization looks at what the value proposition is. You have to look at your market position. My big enough for certain things in our field? We talk about collaboration in a moment, that is the thing, maybe we are not. Maybe we need to look at possible collaboration and where we can do things together to make ourselves substantial enough in order to have the market position, in order to do this. As I said, you have to look at what are the things I'm good at? Again, when we get to collaboration, maybe we can find somebody we can work with that actually has areas that they are good at and they are able to bring that to the table. We needed to know what we do and what we do well.

[Brian O'Reilly] You also obviously have to look at what is needed. You can't do something that nobody wants. You need to identify what services will be needed out there and what you want to be able to provide. And that is when the areas you need to focus on. And then getting in the door. How do I do marketing? How do I do outreach into the community or into other providers. That comes through partially network participation. We obviously, especially as a move to managed care, we want to have a presence in most networks that are in our operating region. Therefore, we can be getting referrals from them so, we want to be participating in networks that are around. We want to look at our competition in our area. We want to determine how we fit in to that.

We want to see whether or not we are better at something, where were set something, where more costly or cheaper so we know how we are able to market ourselves. Continuum of care. A lot of organizations do various different things but we should be making sure we provide a continuum of care in our community because a lot of organizations, especially network selling to deal with agencies that deal with a full continuum of

services, a one-stop shopping concept. And, lastly, we want to look at the high-quality performance ratings.

[Brian O'Reilly continues] Again, we will be moving to value-based payments which is going to require us to be looking at what are the performance indicators in what we are doing and making sure we are feeding in with being a high-quality performance provider. Now, we should be looking for collaborative partners, for a lot of reasons I was talking about. This can only add to the value proposition. If we don't have areas we are good at or areas we are experienced at or we are not of a size that is big enough, we could help out of aligning with different organizations or with even merging with other organizations. So, this can add real value propositions to organizations by looking at collaborative partners. This can be a number of different things. He can be vertical or lateral collaborations. Lateral is the thing where we look for the back office collaborations such as doing business services or technology services together. We have a number of chapters of the system in New York and they are doing these collaborations work they are combining their back offices to save money.

It is a reasonable way to do that and it honestly an effective way. The other thing is technology being so expensive, looking at back-office collaboration, it is an important concept because the fact you are unable to afford some of the technology that you will be required, especially when we move into things like managed-care. And, we should be considering mergers and affiliations. This is something all organization should have on the radar, affiliations, what we can do together. Mergers is a bigger thing. And, we have done a number of different mergers, we've been working with organizations with a different number of mergers. And the first thing, they are very expensive to do. You have all searched the things associated with them including legal costs associated with reorganizing the organization, due diligence that needs to be performed. Setting up, dealing with the pay differentials which very often results in increased expenses. Benefit levels, the time and effort that is involved, the problem with mergers very often is you are bringing in an organization that has a history.

[Brian O'Reilly continues] You are potentially opening yourself up to the exposure of the history of that organization. There is a lot, even simple mergers take a long time and take a good deal of money. So, they have to be selective about this. I had a large organization that actually was looking to merge with a another organization, both were Catholic based organizations. And they had programs that were very synonymous with each other. They were comparable. It took them over a year and a half to actually do this. And, they are still having things that pop up because even when you do a good duty diligence, there will be information coming up that will cost money. It cost them so much that I think this large organization which had a lot of reserves, they that one merger available and I don't see them doing anything soon. So, Mergers need to be picked very carefully. And not just willy-nilly.
Sometimes a better way to do that is to look to take over the programs depending on how the local government does relative to organizations that are going over to a bankruptcy situation. We've dealt with a lot of organizations here that look not to take over the organization's urge but

allow the organization to go under and therefore take over, come right in and take over the program in order to make sure services don't get interrupted. Sometimes, that is a cheaper alternative and a safer alternative to the merger possibility. At this point, I will turn it over to Koy.

[Koy Dever start speaking] Thank you, Brian. I will spend a few minutes to talk about the basics of contracting which could be with a managed care organization or any third-party payer. As I mentioned, when we started the webinar, in my practice, we work with healthcare providers and wavered service providers including IDD providers who are experiencing big changes or anticipating big changes or anticipating big changes in the reimbursement recommend mechanisms. Where these providers and CBO's are moving away from a fee-for-service system in which we build the in the state office of Medicaid or the local Department of Social Services on a fee-for-service basis. To the one that requires a provider of the service to establish a written contract with the managed care organization or another third-party payer and that contract determines how the parties relate to one another and how the parties, how the providers get paid for the services they render. That is a big change. Understand on today's call, we have a diverse group of organizations.

So, some of my examples may relate to managed care which may not be a direct correlation to what you are experiencing but the concepts will ring true. So, in contract basis, if you are in a state where the managed care organizations are expanding, you may get a package in the mail from a managed-care provider with some instructions, to a contract to consider. Or, you may be getting a contract through general conversations with potential pairs. When you get a contract, there usually is a base agreement. That is where the boilerplate language is. They do that way because the boilerplate language may be the same for any type of service provider that the entity is contracting with. We will spend time, it will come back again and again during this presentation. The boilerplate language is not the most fun language to read and understand but it is important that you understand it. And, I will talk about that and a little bit. The program specifics would be in the appendix to the agreement.

That is where there might be specific language that really is written for you and your program. It clarifies, if you're contracted with the managed care organization that has multiple lines of business. They may have Medicare products, they may have a Medicaid product and the contract you have with this payer may be specific to their Medicaid line of business. That could be articulated in the appendix. The appendix might say you're contracted with us for all our lines of businesses. That is one of the things you may see anyone read it and understand it in a contract. Most temporally, it should include a description of the services you are being contracted to provide. And,

[Koy Dever continues] I think this is one of the things you take away anything from this presentation, really know you know your program and the services you provide better than the payer. That is true nine times out of 10. They never know more than you but they may know as much. Don't assume that the payer or the person who wrote the contract really

understands the nuances of your program. You want to make sure that description that is there is accurate. Is consistent with whatever other regulatory requirements you have, but it doesn't require you to do anything you are not allowed to do. This is where you should be, you should agree to make sure if there any language that needs to be added, it is added so you're comfortable with how the services are described in the contract. So, there would be an appendix with the payment rate. A proposed payment rate should be specific to what unit of service is a payment rate applicable to. There may be references to billing codes he had to put on your claim in order to get paid. There might be things that are excluded from the rate.

Again, you know how you currently perform today. How you build today. And you want to make sure that this rate and the units are described in accordance with how you get paid. Don't make any assumption. I use an example. It is an example here in New York for skilled nursing facilities. They have a Medicaid rate. And that Medicaid rate is a per diem rate. And in New York, there was an expansion in managed-care organizations which needed to contract with skilled nursing homes, they didn't spend a lot of time on the rate schedule and they said we will pay you the Medicaid rate. The nursing homes in New York, there are two rates. There is a diem rate and another rate for a cash receipt assessment. Doesn't matter what that is. The point is there are two rates. The nursing home can get that appendix and it says we will pay you the Medicaid rate and the nursing home says that's great, we are covered. But the nursing home assumes the plan knows they get paid two rates. That is where you don't want to make assumptions. The more specific deadline which can be come you bill for certain units differently, it is important that you get that into the contract or if, you negotiate a different way to bill with the managed care entity.

The managed-care entity may say I'm not interested in paying you two rates. I would pay you an all-encompassing rate that includes everything. Therefore, you want to make sure the price they give you covers although services. So, don't be afraid to ask questions, to suggest redlines, to make sure that is clear in both parties. When you are thinking about, when you review the contract, you know, if there's any way of understanding with the potential volume might be, that would be helpful to your assessment. Brian talked about, you want to know what your costs are, cost of providing the service. And, whether the rate being proposed is adequate to cover those costs. And, the other thing to consider in the rate is what is the language about updates? Is there language about an annual update? It is unlikely. But it is worth introducing and if you get language in there about annual updates or some kind of rate review updates that would be helpful. We'll talk a little bit later about if that is not there. Financially, we'll talk about. Once you have assigned contracts, depending on who you are contracting with, you may not be done. You may have to fill out a credentialing practice.

[Koy Dever continues] That is where you have to supply information if your license, you have to show them your licensed and in good standing. If you have surveys or any kind of survey or Department of Health or building surveys, they want to know are you in good standing? Are there plan corrections? They will ask you measure insurance coverage. And then,

finally, not everything is necessarily in the contract. Not everything in terms of how you do business with this entity or managed-care organization. Very often, there is a provider manual there really gets into a lot of detail. So know that is out there for your records. I think that segues into the next slide. So, you have, as a contractee you have responsibilities. And as I said before, the boilerplate language is important for you to pause and understand. If I say in the contract that you agree to adhere to the contractors policies and procedures. And, that is when you want to make sure you understand what that really means. Ask questions. Look at the provider manual. You know, if that's all it says, you might be signing on to much more responsibility than you realize. Some of those responsibilities might be that you agree, that you stay licensed and in good standing. That you are full revelatory compliance with whoever your regulators are.

It might also say if you employ licensed staff, that the staff have licenses of their own, it may require you to check those licenses on a routine basis. These are things you may be doing today but remember that the entity that you are contracting with might say, might have a higher requirement or bar you agreeing to adhere to. There will be insurance requirements, obviously, that will be easy to spot and make sure you can meet those requirements. There are also things where you may agree to stay in communication with the entity with the managed-care organization. They may have a care management function that you have to touch base with, they have quality measures that they you need to report -- you may have notification can requirements. Something happens on your end where maybe there is a regulatory funding that you might be required to notify them.

All of these things are your responsibility to make sure you understand that is going to be on your side of the contract, and in addition to providing the services you're getting paid for. In the contract on competition billing which is critical to everybody, it is important to know what the prior authorization requirements are. Very often, that will not be in the contract but it is in the provider manual. But the payment terms. This is where in the contract it will say you have X number of days from the date of service to file a claim. And, in our experience is what happens is the state, your state may have a requirement that says there has to be for Medicaid fee-for-service, it has been 90 days. And, the managed-care organization has to adhere to state requirements unless each party agrees to different language. On the timely language, just make sure you know what your state requires, it could be that the managed-care organization will say I will put 60 days in the language of the contract but you could try to negotiate to 90 if 90 is a state requirement.

[Koy Dever continues] The point being, understand what that requirement is. If you missed the timely filing deadline, you are unlikely to get paid. It is important to make sure, going in with the requirement is. And, there is prompt payment requirements that are either in state regulations or in the contract. In other words, the plan will say if you submit a claim within the deadline, we have 30 days to pay it. So, this is about education and make sure you're not agreeing to things that are

below the minimum requirements. Okay, so, let's just see here, let's go to the next slide. I just wanted check my time.

Okay. Other contractors. Just to think about. What is the term of the contract? Maybe this is too basic. But, it is worth covering. The language of the contract might say this is a five-year contract and you will be signing on for 5 years. Then, there are termination clauses around being, each party being able to terminate. He might be a one-year contract with an evergreen, and evergreen provision meaning will sign up for year and everyone is bound by this contract for one year and this contract will automatically renew every year thereafter unless one or the other party terminates within the terms of the contract. So, The reason to focus on this is usually when the contract is up for renewal, those are the windows you have to revisit rates. And, revisit other terms of the contract but normally it is the rate. If you don't have an annual inflation factor or if there is some issue, usually within a period of time before the contract auto renewals, that is the time to go to the plan to see if you can renegotiate rates.

[Koy Dever continues] Negotiating rates is not easy. The gushing rate increases is not easy. But it is not something, if you're not covering your costs, you should not be afraid to try. the other thing is, these terms, the managed-care entity can't cancel the contract unless it triggers some of the termination provisions. If they're going to cancel the contract, not for some cause, they have to give you 90 days notice. Whatever notices is required by the contract . That might be a time where you have an appeal process. It depends on whatever entity it is and how your regulated by the state. So, arbitration and dispute resolution. That goes into how the parties agree to resolve contract disputes and I think the stickiest part is the indemnification language. This is what I have to say, if we have clients that are concerned about this, as you should be. You can't really understand it, if you don't understand what it says, it is worth , on an associate basis or through an organization, like the one today sponsoring the call, it is a good idea to educate the group about indemnification language, what it means and how to navigate this , this requires legal review on your part. But I would want to do it in a cost-effective way. You don't want have indemnification reviews for each contract. We talked about this. We talked about the service description.

[Koy Dever continues] Make sure it is specific and clear. I think there's something I wanted to cover on, okay, I think we are good. Let's go to the next slide. Okay. So now, let's say you are, you have a couple of contracts, you are now, you have the contract signed. And now, we will talk about how we are maintaining these contracts? How do we track them? So, really just to start from who in your organization is the keeper of the contract? Who knows what we have agreed to? Who knows how we are maintaining compliance? Where is the contract house? I don't know, I don't think it will surprise anybody that even clients that have a lot of managed-care contracts today, they're sitting in a drawer and not everybody knows, if somebody retires and they don't know where the contract is, that is something you want to avoid. These are living documents, the relationship is a loving relationship. It is important that there is a policy and procedure and a plan in place to say okay,

whose got that contract? Who is working at? Who is making sure we are compliant and where are we keeping it? And by the way, before all that, when a contract comes in what is your organizations process for reviewing that contract? How are those decisions made? Those are decisions to think about? Again, who owns a contract in terms of managing it and ensuring compliance? And then, on our side, the system requirements are really things to consider now even before you enter into a contract is now that we understand we have a contract for services, we understand that we know what services we are providing. We know what rate we have under the contract.

We note that the services require an authorization from the payer, in our example managed-care organization. We need authorization before we can provide the service in order to get paid. So, how are we going to manage that process? How are we going to, who in your organization is responsible for obtaining the service authorization? How do we document those service authorizations? How do we associate and make sure the services we provide are consistent with the authorization? How does that move through the billing and the whole cycle from the time you get the referral and the authorization, provide the service and submit the bill? Those are really, it is much more complicated and as I said before, you need to know what line of building, the timely billing -- billing requirements. If you have 90 days from the date of service to submit a claim, we make sure that claim is submitted within those 90 days or will not get paid. The other thing, this is something that is often articulated outside of the contract, either in a provider manual or other communication policy, if, for some reason, your claim is denied, maybe the managed-care organization denies the claim because they don't have the authorization on file. Or, the claim had the wrong information about the person that was served, that triggers a follow-up, the appeal and the refiling.

[Koy Dever] In those time frames, those time frames are shorter. You don't have another 90 days. If you get a denial, he may have 30 days in order to refile and correct the issue that caused the denial. If you miss that appeal or that refiling deadline, then again, the plan will say I don't need to pay you because you didn't meet our deadlines. You are, your tracking mechanisms for that are really important and obviously, important to get paid and also to be paid timely. It talks about cash flow issues and it talks about the issues that Brian was mentioning, but there certainly is, if you're moving from a fee-for-service business to managed-care business, cash flow is one of the issues to consider.

Maybe you need a line of credit because certainly, the revenue cycle and the time for providing service and getting paid is often longer than the traditional fee-for-service relationship. And then, under, when you have a contract with an entity, I think being able to keep your eye above, keep your head above water and use that as an opportunity to learn more about the businesses so that entity and making sure they will identify some strategic partners consistent to what Brian was mentioning. I'll have another minute so I will just pick up the speed. I will not spend a lot of time on the slide other than to say Brian mentioned a value-based payment and really what does that mean? And really what that means is that pairs want to move away from paying for a unit of service. They

would rather pay for the better quality and better outcomes. So, this slide, I will not spend a lot of time on it. It shows a continuum of how we might move for a fee-for-service environment to up the risk chain under our value-based payment. Let's get that and this is another topic for another day. Excuse me. All right.

[Koy Dever continues] I tried to talk about contracts in general and so now I want to spend a little bit on managed-care in particular. If your state is moving towards managed-care and you're covering in your benefits, some helpful bits of information. Managed-care organizations have to be licensed. They require estate license. They require state license and a federal license depending on the type of services they provide. Therefore, they are highly regulated. they have financial solvency requirements. They have a lot of administrative requirements that they need to maintain. And among those requirements are having a network. You would be part of their network of providers. If you sign a contract with them. And, this network needs to meet adequacy standards. In other words, the state says anyone who, anyone you serve with the managed-care plant must have timely access to the services. Just understand that these entities that you are about enter into doing businesses with our highly regulated. That is why looking at the contract you are getting into and agreeing to their policies and procedures -- they might be more regulated or have more requirements than you do today. Next slide.

I will wrap up. What should you be doing? So, as the state cards in the benefit, managed-care companies do have a network which they will reach out to you for contracts. Do you have associations? Stay involved. For community-based organizations that may not be doing traditional Healthcare Services, you may find your services are more in demand as the concept of population health management really matures. And there are certain services that are ancillary to the healthcare service but help improve the outcomes of the members. If you provide non-traditional services that I think is something that will become more popular over time. Okay, I think I have one more slide. Last slide. So, stay informed about payment initiatives in your state. I mentioned the associations and organizations like this to make sure you have designated in-house people who are responsible for staying informed on what's happening, thought you have a process for contract review internally. Make sure that you know you can ask questions, you can provide feedback. You can try to negotiate. I'm not saying that they are easy things to do but you should not be afraid to do these things.

Make sure your program descriptions are clear. And then, I think, we talked about understand your rights. And your rights relative to submission and prompt payment. I know I ran a little over so I will stop and see if there are any questions.

[Erica Lindquist start speaking] Thank you, everyone. This is a time where you can enter in any questions you may have for Brian and Koy in the lower right-hand corner of your screen. At this time the only question is about the size and yes, the sides and audio recording of this webinar will be available on HCBS business acumen. They will be available at our website and will be available shortly after this webinar. How to

give it a day or two for uploads. If anybody has any questions at this time, please enter them in the Q&A box in the lower right-hand corner of the screen. Koy, I know you're feeling a little bit rushed on the time, while we wait for questions, is there anything that you went through quickly that you wished you would have expended on a little bit more deeply?

[koy Dever] Well, the one slide -- I did go, if he could go back to that BBT, I spend a little more time. There was the continuum, the graph slide that I had, there you go. So, I could walk through what the steps are. The fee-for-service we know, that's probably where most of the people on the call, that is probably where most of the organizations on this call are. The next phase is if you provide service on fee-for-service basis, your payer may give you a bonus payment if you help them meet certain quality measures. Typical measures in healthcare is avoidable hospitalizations. But, there be other quality measures relative to the services you provide, maybe is getting a flu shot. Or -- the first step is, I provide the service and you pay me, but you pay me for quality?

The next one would be, even within the performance bonus, there might be a withhold from your payment and you earn that withhold back if you meet the quality measures. So, that is kind of like a upside- downside performance bonus. Then we get into game sharing. That means that basically, there is a budget or there is a set of healthcare services and there are some, if there are savings against the budget that is mutually agreed-upon that the provider of the service can share in some of the savings. So, that is game sharing. But in the game sharing scenario, there is no risk that you will lose money if the services or the cost of the care exceed the budget. That is kind of an upside only provider game sharing fee-based payment relationship. And then, there might be one where the next one is partial risk. That is where, I would say probably the organizations on this entity would not be the entities that go at risk but you might be part of a group of entities that come together and share risk.

Or, you might be subcontractor to an entity that is sharing risk. I'm not suggesting that the organizations on this call will go at risk but is important to understand the concept. If the managed-care organization has a budget, it could be the total cost of care or it could be a slice of the cost of care, a budget with her provider and they say we will work together, if we meet our quality outcomes, where not looking to cut services, maybe what to achieve savings but improve quality and outcomes and if there are savings against the budget, we will share in the savings. If, if you spent more than the budget, under a partial risk arrangement, the entity would be responsible to pay back some money to the managed-care entity. These are partial risk. Upside and downside risk And finally --

[Erica Lindquist interrupts Koy]
You have a question go Ahead.

[Erica Lindquist starts speaking again] We do have a question that is coming in. When negotiating prices, what information supports the means

to negotiate, what data would be beneficial to provide? Can you renegotiate for the contract renewal?
[Koy Dever start speaking again] So, to answer the question is broadly imposible, most importantly, is to know what your unit costs are and Brian, I don't know if you want to collaborate on that,

Brian O)'Reilly speaks again] We talked about it, is looking at the various components of your cost structure and breaking it down here component, breaking it down between fixed and variable and figure out how much acuity the low cost you and include your costs and also anything unique to services you may not be used to doing.

Koy Dever speaks again] Yep, the other thing, if there is currently an established rate for the services you provide, maybe there is a Medicaid fee-for-service rate, that is another part of information. Brian would argue, Koy, that is not a great point because the Medicaid rate is not sufficient to cover the cost. But, it is a business decision you have. You have, you do know your costs, you need to understand the volume and the variable and the Medicaid rate. I think the organizations on this call, they are not in the, you are not in the most powerful negotiating position but that doesn't mean you have the ability to try and negotiate and you shouldn't accept something you can't live with it. I don't want to make it sound like it is easy to negotiate with healthcare plans, but you should not accept something you cannot sustain.

Erica Lindquist] Are right, a couple of more quick questions. One is how do you go about establishing managed-care contracts? I think that one is a how to get into the door?

Koy Dever] Yeah, that is a great contract -- I to go with the network adequacy. The time to really keep your eyes open is when the state starts to carve the benefit into managed-care. So, in order for the managed-care organization to get approval to do that line of business in the state, they need to show the state that they have a contract with that network. Some states will require that they, I know we are out of time, some states require that the contractors Have contact with all providers of the service but not always. And so, it is being attuned to when those are happening and doing as much as reach as possible. Often, the states want you as a provider to get contracted so if you're having trouble, you can reach out to the state as well.

Brian O'Reily] And, they will want to contract, most providers, to make sure the network is sufficient. You need to make sure you are on the radar.

Yep.

Erica Lindquist] The last one, it ties into the review you're doing here on the payment model concept. It's, the term p.m.p, per member per month, where does that fit in to the continuum?

[Koy Dever] Oh, okay. per member per month is usually how the plan, the managed-care organization gets paid. They get paid one set rate per

member month and they take that money and distributed out to their network providers based on the contracts that we spent this last 20 minutes talking about. So, you might, instead of getting paid on a visit basis, you might be approached by plan to say, we don't want to pay you visit but we will pay you per person per month that you served. month. Obviously, a lot goes into that, the calculus, if that is, that as we start to get into risk.

If they say we are going to pay you the equivalent of five visits, $500 per member per month, but for that, you have to do, you might do 10 visits or he might do for visits. That is where there is a little bit risk sharing when you get into per member per month is something you want to be very careful about. That way, you're accepting some financial risk. I hope that makes sense.

[Erica Lindquist speaks] That's perfect. Excellent. Thank you to both Brian and Koy for preventing our webinars this month. Ink you to everyone for joining us. Again, this webinar is going to be archived. We will be available at the HCBS Business Acumen website. We will not be having a webinar in August and hope that many of you will join us at the conference in Baltimore. But, we will be back up and live with our webinar again in September. So, thank you all, talk to you soon.

Thank you.

[Event Concluded]