Resource Guide

Model Contracts for Community-Based Integrated Care Networks: Annotations

Introduction

The large-scale transition to value-based reimbursement has incentivized health care providers to maintain and improve population health, rather than simply providing additional services. Thus, many providers are now exploring ways to address the social determinants of health. This includes contracting with aging and disability community-based organizations (CBOs) to provide services for individuals with complex medical and social needs.

Like providers, payers (including Medicare Advantage plans, Medicaid managed care plans, self-funded employee health plans and fully insured health plans) also are interested in working with CBOs to address the social needs of those who are enrolled in their plans. A 2020 **Milliman white paper**[1] emphasizes this point, showing a 64 percent increase from the 2020 to 2021 plan years in Medicare Advantage coverage of supplemental benefits, such as adult day and in-home support services.

Given that many CBOs do not have the resources to negotiate or manage these relationships with providers and payers, they often look to participate in networks of CBOs that share the cost and burden of administrative services related to health care contracting across multiple agencies. Also, most providers and payers prefer to contract with a single network as opposed to entering into contracts with multiple CBOs. Providers and payers look to these networks to establish and enforce performance standards that its participating CBOs must adhere to, thus ensuring the quality of the services provided.

While there are a handful of successful CBO networks operating across the country, these business arrangements are new to many providers and payers. To help foster these new relationships, the Aging and Disability Business Institute has provided three sample contracts: (1) **a contract between a network and its participating CBOs**,[2] (2) **a contract between a network and a provider**,[3] and (3) **a contract between a network and a payer**.[4]

These sample contracts are examples of how relationships between CBO networks and payers and providers may be structured to define the duties and responsibilities of involved parties. They are intended to help the reader appreciate the range of issues to be addressed in negotiations. **These sample contracts do not constitute and cannot be relied upon as legal advice. CBOs and networks should engage qualified legal counsel when pursuing such business arrangements.** Each arrangement is unique, and legal counsel is needed to appropriately identify and address specific requirements and distinct risks an organization may face in a particular arrangement, including laws and customs that vary based on your state or community.

[1] Millman, *Review of Contract Year 2021 Medicare Advantage supplemental healthcare benefit offerings,* https://www.bettermedicarealliance.org/wp-content/uploads/2020/11/MA-2021-Supplemental-Benefits-Milliman-Brief_202011132.pdf.

[2] Aging and Disability Business Institute, *Network-CBO Model Contract.* https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2021/02/FINAL-sample-contract-Network-and-CBOs.docx.

[3] Aging and Disability Business Institute, *Network-Provider Model Contract.* https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2021/02/FINAL-sample-contract-Provider-and-Network-Entity.docx.

[4] Aging and Disability Business Institute, *Network-Payer Model Contract.* https://www.aginganddisabilitybusinessinstitute.org/wp-content/uploads/2021/02/FINAL-sample-contract-Payer-and-Network-Entity.docx.

Aging and Disability BUSINESS INSTITUTE
Connecting Communities and Health Care

The following annotations explain the purpose of specific sections within the sample contracts and identify alternative arrangements a CBO may consider. Again, these discussions are not exhaustive, and qualified legal counsel is needed to help your CBO fully appreciate the specific duties and risks it will assume under a specific arrangement.

Generally speaking, it is in the best interest of a CBO or network to present a payer or provider with a draft contract for consideration, rather than waiting to receive a draft contract from the payer or provider. However, keep in mind that providers and payers enter into dozens—if not hundreds—of contracts each year and some may try to retrofit one of their standard contracts to use in contracting with a CBO network.

In these cases, a network lead entity or CBO may use these sample contracts to help understand the duties and risks it is being asked to assume under such draft contract and/or to propose alternative language. CBOs should always call upon qualified legal counsel to develop their own contracts, and evaluate and negotiate draft contracts that have been provided by a provider or payer.

I. Annotations to Network-CBO Model Contract

A network participant contract defines the relationship between the network lead entity (i.e., the entity that will contract with providers and/or payers) and its participating "network" of CBOs (the entities that will perform the services for which the network lead entity contracts).

Whereas Clauses. The introductory whereas clauses describe the parties' relationship in general terms and their purpose in entering into the contract. Your CBO prefer to include a more specific description of the relationship and purpose to most accurately reflect the parties' intent in your situation.

The whereas clauses in the sample contract reference **Exhibit A**, which defines the specific services the CBO is offering to provide through provider and payer contracts with the network lead entity. As you will see, **Exhibit A** is blank. Your CBO will need to develop detailed descriptions of the services to be provided to include in this exhibit. However, this list should remain flexible enough to accommodate different details (e.g., processes, performance metrics, volume, geography, etc.) that may differ among multiple contracting entities.

Section 1 of the sample contract details the network lead entity's duties, which revolve around its administrative role. That role includes linking individuals requiring services to the CBO and establishing the standards to which the CBO must adhere in providing those services. As with **Exhibit A**, these duties should remain general as specifics about services to be provided under any particular provider or payer contract will be outlined in that contract.

Section 2 outlines the process by which a CBO becomes obligated to provide services under specific network contracts. The network entity presents the key terms of such contract to the CBO, which then has 10 business days to review the contract. This time period may be adjusted to meet your specific needs. If the CBO does not reject the contract during that time period, it is then obligated to perform under that network contract.

Instead of this "opt-out" approach, you may prefer to have CBOs "opt-in" to each network contract (i.e., a CBO must affirmatively accept a contract before that CBO has any obligation under that contract). This approach affords a CBO the opportunity to negotiate specific provisions in a network contract to protect its specific interests. However, it is important to emphasize that the network entity likely will find it difficult to secure any contract with a provider or payer if the network entity cannot demonstrate to providers and payers a significant, tangible level of commitment from its participating CBOs.

In either case, if the CBO rejects the network contract, it is prohibited from directly or indirectly contracting with that provider or payer for similar services for one year. This non-compete clause prevents a CBO from taking advantage of the network entity's efforts in negotiating with a provider or payer to strike a deal the

CBO believes is more favorable to its specific interests. If a CBO were to be allowed to directly negotiate similar arrangements with the provider or payer, it would, in effect, be diluting the value and threatening the viability of the network entity from the provider and payer perspective.

On the other end of the spectrum, you may prefer to require all participating CBOs to perform under any and all contracts into which the network entity enters (i.e., no opt-out process). Because network relationships are somewhat new for CBOs, however, it is unlikely many will be willing to place such a level of trust in the network entity, even if that entity is governed by participating CBO representatives.

The sample contract does not include a provision permitting a CBO to terminate its participation under a specific network contract. Instead, a CBO wanting to take such action would address the matter with the network entity through the dispute resolution process. This is an example of how a contract cannot address every contingency, but instead should include a process by which the parties can address these matters. If this is a matter of significant concern to potential participants, you can negotiate and include a provision in your network's participant contract addressing termination of participation under specific network contracts.

Section 2 also details the CBO's duties in providing services. Note the sample contract does not include specific performance standards. Instead, the CBO agrees to adhere to those standards as they are defined by the network entity. Alternatively, the parties may want to include some standards as an exhibit to the network participant contract if potential participants are unwilling to agree to adhere to performance standards yet to be defined. However, doing so may make contract negotiations with payers and providers difficult. That is because payers and providers may have specific requirements and standards that, for a variety of reasons, may be non-negotiable. In this case, the network entity needs the flexibility to agree to accept a reasonable level of variation from contract to contract.

These sample provisions regarding the parties' respective duties illustrate one way to structure the relationship between a network entity and a participating CBO; these provisions should be tailored to the specific relationship contemplated by the parties.

Section 3 of the sample contract addresses compensation for services furnished by the CBO. Because the manner in which a provider or payer compensates a network entity can vary significantly, Section 3 states the network entity will compensate the CBO in a manner consistent with each network contract. The specific payment terms then would need to be determined on a contract-by-contract basis. One matter to address in any compensation provision is whether the network entity's obligation to make payments to the participating CBO is dependent on the network entity having received payment from the provider or payer. In most cases, a network entity will not have the resources to make any payment to the CBOs until it receives payment from the provider or payer. As such, payment terms may trigger the start of any timeframe requirements for the network entity to pay the CBO with the date of receipt of payment from the contracted entity.

Section 4 of the sample contract permits a CBO to use subcontractors in providing services, but only to the extent the CBO obligates the subcontractor to the same terms and conditions in the network contract. Alternatively, a network entity may insist on directly contracting with any person or entity providing services.

Section 5 of the sample contract is a relatively standard **Term and Termination provision**. You should adjust the time periods to meet your specific needs. For example, some governmental entities are prohibited from entering into "evergreen" contracts. You may also want to address other consequences of termination. For example, you may consider a non-compete clause (i.e., prohibiting the CBO from contracting directly with a provider or payer with which the network entity contracted for a specified period). This would be distinct from the non-compete clause prohibiting a CBO from contracting with a specific provider or payer after having opted-out of the network contract with that provider or payer.

Finally, **Section 6** of the sample contract includes several standard miscellaneous provisions. Unlike those in the preceding sections, these provisions do not address the parties' respective rights and responsibilities. Instead, they concern the mechanics of the parties' relationship (including dispute resolution) and the interpretation of the contract's language.

As you will see, the provision regarding insurance coverage imposes a duty to secure and maintain "adequate" insurance coverage. In many cases, parties will insist on specific levels of coverage, which may prove challenging for smaller organizations. It is wholly appropriate to question a party's reason for insisting on specific levels of coverage; often, certain requirements are included as a matter of course and can be negotiated to better meet the parties' actual needs.

This section does not include an **indemnification** or **hold harmless provision**. Under contract law, damages for **breach of contract** equal the amount necessary to put the non-breaching party in the position that party would have been in had the work required as part of the contract been performed. With indemnification, one party agrees to protect the other party against losses arising from a third-party claim related to the contract (this may include legal fees and other expenses). For example, a network lead entity could insist on an indemnification provision requiring the CBO to defend the network entity against any claim asserted by a provider relating to the CBO's failure to perform the services appropriately.

Because the scope of indemnification provisions is heavily negotiated and often heavily litigated, these sample contracts do not include such a provision. Also, many governmental entities are prohibited from providing indemnification. If you want to include an indemnification provision in your network participant contract, make sure the scope is clearly defined—there should be no question about the losses for which the CBO would provide indemnification. Many CBOs will not agree to any contract with an indemnification provision as it exposes the CBO to unpredictable financial losses.

II. Annotations to Network-Payer/ Provider Model Contracts

Once the network is organized with participating CBOs, the network lead entity can pursue contracts with providers and payers interested in securing the types of services furnished by the participating CBOs. The first step in the negotiating process is to understand the problem the provider or payer wants to solve by contracting for CBO services. For example, a hospital may want to reduce emergency department (ED) "frequent flyers" by addressing the conditions causing these patients to go to the ED frequently. By fully appreciating these needs, your organization will be in a better position to define the **scope of services** and will better understand the value of the services.

The introductory **whereas clauses** in the sample contracts describe the parties' relationship in general terms and their purpose for entering into the contract. You may want to include a more specific description of the relationship and purpose to more accurately reflect the parties' intent based on your negotiations.

The whereas clauses in the sample contracts also refer to **Exhibit A**, which defines the specific services to be furnished by the network entity through its participating CBOs (referred to as "Core Services"). As you will see, **Exhibit A** is blank. You will need to develop detailed descriptions of the services to include in this exhibit. Keep in mind that **Exhibit A** may be amended from time to time, as the needs of the provider and/ or payer's needs change or the network expands to include CBOs providing different services. Additionally, your network may wish to provide a basic set of services in **Exhibit A** with the knowledge that this basic set of services will be the basis for negotiating a specific contract with a payer or provider entity rather than the absolute full description of all the details related to any specific contract.

The whereas clauses also refer to **Exhibit B**, which defines the process the parties will use to establish specific eligibility criteria for individuals to receive Core Services. As with **Exhibit A**, these criteria will reflect the network entity's expectations regarding potential priorities for the provider's or payer (e.g., individuals with specified conditions recently discharged from the hospital to their homes) or the network's capabilities (e.g., a network may lack the capability to work with homeless individuals) and will be the basis for the network entity's negotiations with providers and payers rather than a rigid set of criteria. The bottom line is to establish a core framework from which flexibility within reasonable limits will be key.

Section 1 in the sample contracts defines the process by which the provider will refer patients and the payer will refer beneficiaries to the network entity for services. While this section establishes the parameters of the process, the parties will have to work together to define the details.

The sample provision sets a minimum number of referrals the provider or payer is required to make and a maximum number of referrals the network entity is required to accept during a specified time period. It also addresses the key components of the referral process and ongoing interactions with the beneficiary. The process begins with initial contact with the beneficiary and the development of a preliminary "Social Care Plan" for the individual. It continues with ongoing communication between the CBO providing services and the provider or payer, including appropriate documentation of all services provided.

Section 2 in the provider contract includes a provision that details the parties' respective responsibilities if the payer intends to bill Medicare for chronic care management services based in part on the services furnished by the CBO. A provider may be interested in such an arrangement to help offset some of the costs associated with the services. To accomplish this, however, the parties must establish a specific process to ensure all Medicare billing requirements are satisfied. If the provider does not intend to seek such reimbursement, this provision should not be included in your contract.

Section 3 in the sample payer contract and **Section 4** in the sample provider contract address cooperation among the parties to evaluate the impact of the services. A network entity should take advantage of every opportunity to quantify the value of its participating CBOs' services. Engaging the provider or payer in the evaluation process should give them a vested interest in the success of the program.

Section 4 in the sample payer contract and **Section 5** in the sample provider contract address the compensation the provider or payer will make to the network entity for the contracted services. This provision assumes a flat rate monthly payment, also known as a PMPM (per member per month), for serving a specified number of patients or beneficiaries for a specified period, based on an average cost per patient or beneficiary to the network entity for providing services, with provision for additional payment if the network entity actually serves a higher number of patients or beneficiaries. This approach has the advantage of providing the network entity with a reliable cash flow. A provider or payer, however, may be unwilling to pay for any services it may not use. Alternatively, the network entity could establish a fee schedule, track specific services provided and submit invoices to the provider or payer. Specific payment methodologies should be considered carefully by the network entity and its participating CBOs. Pros and cons of various methodologies are addressed in **Pricing CBO Services in a New Health Care Environment**,[5] a resource guide from the Aging and Disability Business Institute.

Section 5 in the sample payer contract and **Section 6** in the sample provider contract include the network lead entity's representations to the provider or payer regarding how the network entity will conduct its business operations. The three representations included in the sample contracts—**compliance**, **no violations** and **authority**—are standard provisions. Given their potential liability to third parties, providers and payers will insist on assurances that parties with which they contract will not expose them to liability.

Section 6 of the model payer contract and **Section 7** of the model provider contract are relatively standard **Term** and **Termination** provision and **Section 7/8** includes several standard **miscellaneous provisions**. Reference the discussion in the preceding section regarding the same provisions in the sample network participant contract.

[5] The Aging and Disability Business Institute, *Resource Guide: Pricing CBO Services in a New Health Care Environment,* https://www.aginganddisabilitybusinessinstitute.org/adbi-resource/pricing-resource-guide-to-help-cbos-in-new-health-care-environment/.

This publication was produced for the Aging and Disability Business Institute by Martie Ross (PYA, P.C.) with support from Paul Cantrell (Clear View Strategies, LLC). Led by the National Association of Area Agencies on Aging (n4a) in partnership with the most experienced and respected organizations in the Aging and Disability Networks, the mission of the Aging and Disability Business Institute is to build and strengthen partnerships between aging and disability community-based organizations and the health care system. Funded by The John A. Hartford Foundation, The SCAN Foundation and the Administration for Community Living, the Aging and Disability Business Institute provides community-based organizations with the tools and resources to successfully adapt to a changing health care environment, enhance their organizational capacity and capitalize on emerging opportunities to diversify funding. Learn more at ***www.aginganddisabilitybusinessinstitute.org****.*

Martie Ross, principal author, is office managing principal at PYA and serves as a trusted advisor to providers navigating the ever-expanding maze of health care regulations. Her understanding of new payment and delivery systems and public payer initiatives is an invaluable resource for providers seeking to strategically position their organizations for the future.

Paul Cantrell, editor, is president at Clear View Strategies, LLC and has been working with and committed to the success of Area Agencies on Aging and other community-based organizations for more than a decade. Cantrell has served as a business acumen consultant to the National Associations of Area Agencies on Aging (n4a) for more than eight years. Previously, Cantrell served as health insurance policy director for the Georgia Insurance Department, vice president of Product Development for a coalition of Georgia's largest corporations and corporate director for a leading managed care company.