HCBS BUSINESS ACUMEN CENTER

DISABILITY NETWORK BUSINESS STRATEGIES:
A Roadmap to Financial and Programmatic Sustainability for Community-Based Organizations

Step 4: Grow and Develop

Grow and Develop Your Organization

ADVANCING STATES

Contents

BUSINESS ACUMEN describes an organization's ability to understand and address business conditions in a way that leads to the organization's desired financial and operational outcomes. For community-based organizations (CBOs) serving people with disabilities, strong business acumen will improve the organization's ability to sustain or even grow their programs. The HCBS Business Acumen Center is devoted to providing resources to disability-focused CBOs to facilitate successful business practices. The Disability Network Business Strategies Roadmap is one such resource.

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Step 4: Grow and Develop

Grow and Develop Your Organization

Now that you have completed a review of the stability of your organization and addressed any potential issues, you may want to capitalize on new business opportunities. Financial stability, good human resources (HR) practices, solid business processes, effective use of technology, and accurate financial reporting prepares your organization for growth and development.

In **Step 1: Prepare**, you completed an environmental scan and a strengths, weaknesses, opportunities and threats (SWOT) analysis to identify areas in which your organization can grow and prosper. For example, you may have identified opportunities to work with new payers, develop a service line or expand into another territory. In **Step 2: Plan**, you used this information to develop a strategic plan. Now it is time to operationalize those strategies.

Things to consider as you review this module:

- Who do you want to pay for the services you offer?
- Do you know how to establish relationships with new payers?
- What is important to the potential payer?
- What is your value proposition? How will you fill their needs?
- How do you get in the door?
- How will reimbursement be structured?
- Will you need to negotiate new contracts? What will the terms of those contracts be?
- Are there any risks that you can anticipate in the near future?

UNDERSTAND YOUR PAYERS AND PARTNERS

All organizations must have a steady stream of revenue to fund its programs. A diverse payer portfolio is one strategy to ensure you retain control of where your revenue comes from. Payer diversity allows you to have a steady flow of income and creates resilience should there be a problem with any given funder.

Part of business development requires that you seek out new relationships. To do so, you must first do your research. You need to know who it is that you want to work with; learn about their business, understand what their needs are, identify how you can help fill those needs, and develop a value proposition. From there, you need to launch that relationship. You need to get in the door, talk to the right people, negotiate effective terms and execute an agreement. All of this can take much more time and effort than one plans for.

Who do you want to work with?

In the environmental scan, you will have identified potential payers in the area. Now is a good time to review that list and update it since you are about to create a more tactical plan to develop relationships with those potential payers. At this point, keep all options open and explore how you may be able to work with all potential payers.

What are their needs?

Are they a managed care organization (MCO) that wants to both improve health outcomes and control costs? Are they the state agency who wants to reduce the number of people who live in institutions? Are they a county or city that wants to increase the quality of life for people in its community?

Review on-line information about each potential payer:

- What is their mission?
- What do they strive to achieve?
- What is the purpose of their program?
- How are they paid?

This is part of the information that you will need in order to build your value proposition.

UNDERSTAND REIMBURSEMENT METHODOLOGIES

The mission and vision of your potential payer is important, but so is money. How money flows through their organization may impact how payers pay you. Medicaid is generally the primary payer for many long-term service and support (LTSS) services disability CBOs provide. As a result, Medicaid shapes most of the reimbursement structures and methodologies used.

State Medicaid LTSS programs may operate in a fee-for-service (FFS) environment or a managed care environment. Fee-for-service simply means that providers are paid for each unit of service they provide. In a managed care system, the MCO is paid a capitated rate and then must provide all required services to the member within the scope of the contract. State contracts with the MCO will vary per state design. For example, some services or populations may be carved out of the benefit package. Benefit packages and contractual requirements may also be modified at the time of renewal of the MCO's contract with the state. The more you understand the program that your potential payer works under, the more you will understand what is important to them and where they seek to create savings.

A capitated rate is a set amount, usually referred to as a per member per month (PMPM), paid to the MCO regardless of the amount of services the individual uses. Some individuals will have an average utilization less than the PMPM and others may average more than the PMPM. The MCO needs the amount they receive in PMPM to cover the total amount of services all members use in addition to a margin. This incentivizes MCOs to manage costs through rates or utilization, such as the use of less expensive, usually preventive services in the area of primary, or medical care. This may also include the use of less expensive services in the community rather than institutional care.

Accountable Care Organizations (ACOs) are a variation of managed care. In some cases, CBOs, may be part of a provider led ACO. In these rare instances, CBOs may accept a capitated rate from Medicaid for all the LTSS needed by the member. ACOs can be set up under either a shared savings or a shared risk model. A shared savings model means that the ACO shares in any savings it creates for Medicaid, but it does not assume any risk for increased costs. In a shared risk model, the ACO shares in the savings, and generally receives a higher percentage than in the shared savings model, but they are also at risk for the high costs some members may incur.[1]

The Program of All-Inclusive Care for the Elderly (PACE) is another variation of managed care. The PACE organization receives a capitated payment, PMPM, just like an MCO, that covers all of the individual's medical care and LTSS needs. Medicaid and Medicare may both pay a portion of the PMPM for dual eligible individuals.

[1] National Association of ACOs. https://www.naacos.com/acos-and-financial-risk.

Regardless of how the MCO (or ACO or PACE organization) is paid, they may still use FFS rate structures or methodologies to purchase services for their members. As the CBO, you may still see very familiar rate structures if you contract with an MCO.

The most common rate structures are:

- Fee schedule;
- Negotiated market rates;
- Tiered rates;
- Bundled rates; and
- Cost reconciliation.[2]

There are pros and cons to each rate structure both from the payer's and the provider's perspective

Table 1: Common Reimbursement Methods

FEE SCHEDULE	■ Uses a fixed, pre-determined amount per unit of service. ■ Most common rate structure in home and community based services. ■ Payer often uses a model rate approach to develop the fee schedule attempting to quantify or estimate all costs necessary to provide one unit of service.
NEGOTIATED MARKET RATES	■ Uses the market price of the service. ■ May be some negotiation on a provider by provider basis. ■ Payer may institute a market rate maximum (or ceiling) or annual expenditures cap.
TIERED RATES	■ Varies payment for a service by identified characteristics of the beneficiary, the provider, or a combination of the two. ■ The most common form of tiered rates are developed to recognize cost differences based on the acuity level of the beneficiary. ■ Can also be used to vary rates geographically.
BUNDLED RATES	■ Uses pre-determined rate for a fixed amount of time and includes the delivery of multiple (bundled) services. ■ Most useful when multiple services are difficult to separate by component. ■ Episodic payments are a variation of bundled rates in which the fixed amount of time is centered around a medical event.
COST RECONCILIATION	■ Providers receive an interim reimbursement rate for providing services that is later adjusted after the provider files a cost report. ■ Highly accurate. ■ Labor intensive for the payer and the provider.

[2] Centers for Medicare and Medicaid Services. "Rate Methodology in a FFS HCBS Structure." https://www.medicaid.gov/sites/default/files/2019-12/rate-setting-methodology.pdf

Fee Schedules are very predictable but may encourage overuse of services since the provider generates more revenue with each unit of service provided. Payers may limit use with requirements for pre-authorization or service caps.

Negotiated Market Rates are not really feasible for high volume services with large numbers of providers. They work best with limited provider pools and one-time services that are highly customized like home modifications or pest control services. For the payer, these costs are not at all predictable so there are likely to be limits such as caps on total costs and perhaps the hours of work that can be included.

Tiered Rates can introduce more variability for payers and their budgets. It can be challenging to project average rates based on acuity levels or geographic locations of individuals that utilize the service. With acuity based tiers, there is typically an assessment, often by a third party, that determines the tier in which the individual falls. Providers may "cherry-pick" in these circumstances and either not want lower level individuals or higher level individuals depending on how adequate the provider finds the rates to be.

Bundled Rates can be useful when multiple services are provided and sold as a package together. For example, in a group home, consumers may receive personal care, homemaking, and transportation services. Reimbursement for these services may be set at a single charge that covers all the assumed or average costs plus margin for all of the services. Bundled services can work well for providers and payers if the service is clearly defined and the rate considers all the service elements.

Cost Reconciliation is a much more complex reimbursement method. It can be costly and time consuming for both payers and providers. It does, however, have the potential to most accurately represent the actual costs of the service. Cost reports from cost reconciliation can be used to set rates in a fee schedule. This combines the best elements of each method.

Value Based Purchasing (VBP) refers to provider payments linked to quality outcome measures. VBP programs frequently use one of the common rate structures as a base and then provide an add-on payment if certain metrics that incentivize improved quality of care are achieved. Several states have VBP programs for nursing facilities. In Indiana there is an add-on to their Medicaid payment based on a points formula that considers their survey scores, CMS quality measures, staff retention, and other measures. A few states implement VBP programs in home and community-based services (HCBS) and MCOs may use this model in contracts with providers.

The reward in VBP models increases along with the risk. Figure 2: Examples of Value Based Purchasing Options provides an example of models that see increases in rewards along with increased risk.

Figure 1: Overview of Reimbursement Structures

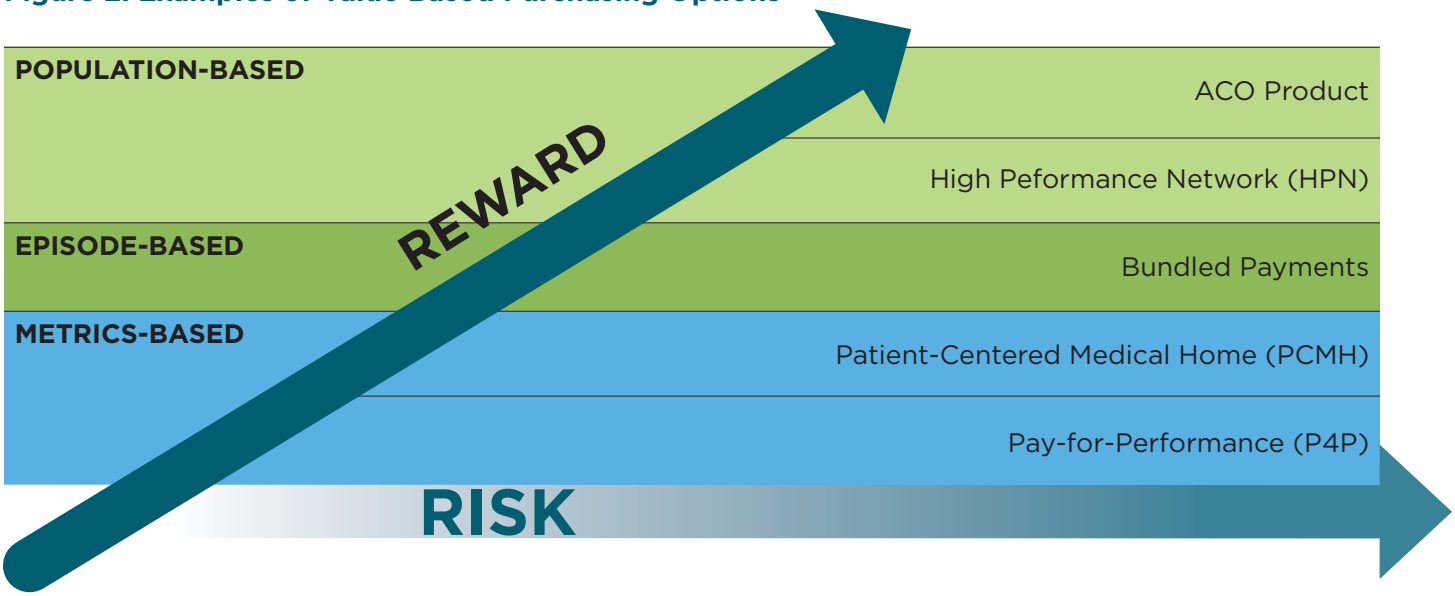
Fee-for-Service Versus Managed Care Systems	
Capitated Rates, PMPM rates for all services in the scope of the contract are generally found in contracts between Medicaid and Medicare and MCOs or ACOs.	The MCO or ACO's contract with CBOs and other providers likely will revert to a fee-for-service arrangement.

Common Fee-for-Service Reimbursement Structures				
Fee Schedule	Negotiated Rate	Tiered Rate	Bundled Rate	Cost Reconciliation

Value Based Purchasing		
Still uncommon in HCBS	Generally still utilizes common fee-for-service structure for base rate.	Add-on payment if certain quality metrics are achieved.

Larger organizations such as health plans or hospital systems may utilize more complex structures where the risk is greater.

Figure 2: Examples of Value Based Purchasing Options



PRICE YOUR SERVICES

Before you can negotiate a contract or set rates, your organization needs to understand how much it costs to provide those services. In **Step 3: Stabilize** we discussed how to use financial reports to manage your business, including the categories of costs and possible cost allocation methods. You can use this same information when you price and negotiate your services. To maintain a sustainable business model, the cost to deliver a service cannot exceed the revenue generated. Costs can shift over time, which is why it is necessary to evaluate all factors when you analyze service costs.

To understand the cost of a service, divide the total cost by the number of units or the units of services delivered. This formula becomes more complicated for CBOs that provide multiple services. For example, where some costs, such as overhead, billing, etc. support several functions, you will need to understand or estimate the cost of each of those functions and apply them individually to your service lines. Review the discussion of cost centers and cost allocation in **Step 3: Stabilize** for further detail on how to understand your current costs.

$$\frac{\text{TOTAL COST}}{\text{Number of Units Produced or Services Delivered}} = \text{SERVICE COST}$$

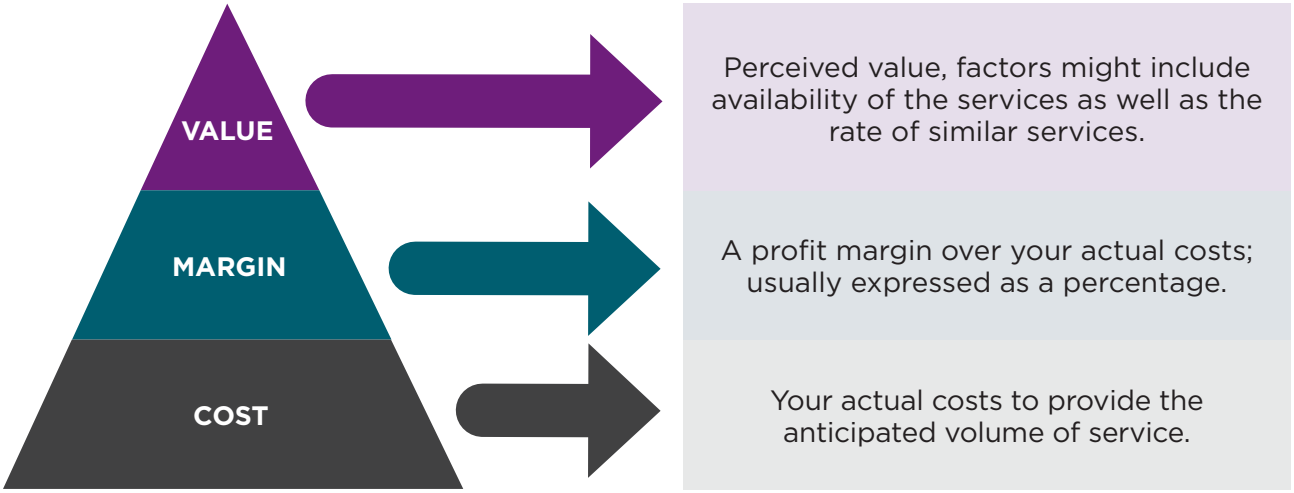
You may find that you need to reconfigure how your organization prices its services to work with certain payers. For example, services that were once bundled may now need to be offered a la carte to the purchaser and vice versa in other circumstances. Again, you will need to examine how your fixed costs, such as labor and overhead costs, are allocated to each of the services offered. Even fixed costs can become variable if the number of service units provided increase dramatically. For example, you might need additional payroll clerks or additional office space in order to meet the demands of the new contract. The cost of a unit of service may also go down with a dramatic increase in service units provided. The volume of service you will provide under any new contract is relevant in cost calculations.

Example 1: How Unit Cost May Vary with Volume

Changes in Volume	Volume	Variable Costs	Fixed Costs	Unit Cost
Baseline: $150,000 in costs/10,000 units = $15.00/unit	10,000	$100,000	$50,000	$15.00
Service units and variable costs increase with no change in fixed costs, reduces the unit cost: $200,000 in costs/15,000 units = $13.33/unit	15,000	$150,000	$50,000	$13.33

To prepare for negotiation, you need to understand what your organization needs to receive for reimbursement in order to cover costs – broken down to the unit cost per service. However, to keep your organization healthy and potentially expand your business, you also want to seek a margin. Review the cost of your service, compare that to the price and access of similar services in the market, and gauge the value that your service brings to the other party and the willingness-to-pay of the other side. These factors along with your cost, determine the rate you may charge for a service.

Figure 3: Elements to Determine Rates



DEVELOP YOUR VALUE PROPOSITION

A value proposition is how you describe how your product or service solves a potential payer's problem or improves an outcome for them, quantifies that value, and differentiates your organization from others that may offer similar services. You want your value proposition to be articulate and compelling.

We help X do Y by doing Z.

X = the payer

Y = the outcome (improved quality, better outcomes, reduced costs, compliance) or problem you solve

Z = your CBO's services

CBOs that serve people with disabilities have a unique advantage in the LTSS system since most have risen in direct response to a consumer need and demand. It is common for CBO owners to have family members who are consumers, or even consume services themselves. That insight, connection, and acute understanding of consumer needs is a unique asset your CBO likely holds. Connect this information with strong financial management, personalized services, and the ability to improve quality or outcomes to articulate your organization's value proposition.

Your value proposition may be different for different payers because different payers have different needs. Most CBOs understand consumer needs and can easily speak to the customer experience and quality of life outcomes. However, many struggle to articulate value in business terms, since the purchaser of services is often not the end consumer. Purchasing entities (e.g., MCOs, Medicaid agencies, private insurance carriers, ACOs, etc.) will likely be the conduit between the services you offer and the end consumer (the individual who receives services and supports). These organizations have needs beyond those of the consumer.

DESCRIBE THE VALUE OF YOUR SERVICE

Example: A CBO is providing personal care services for members enrolled in a Medicaid MCO.

Value to consumer: Delivery of personal care; satisfaction; access to quality care.

Value to MCO: Integration with community services, behavioral health/recovery, and others positively impacts health outcomes and quality of life. Cost savings as a result of improved health outcomes, reduction in hospitalizations and communication/ coordination with other providers.

The growing awareness and need to impact social determinants of health (SDoH) can act as a bridge to connect CBOs to payers of health services. SDoH are the environmental conditions that impact the health of people. It includes such things as access to food, housing, transportation, and employment. The care CBOs provide in the community directly impacts the health outcomes that payers monitor. When individuals have access to nutritious food, stable housing, and are integrated with their community overall, health improves and there is a cost-savings case to be made to the payer of health services. The Centers

SOCIAL DETERMINANTS OF HEALTH: THE INTERSECTION OF MEDICAL AND SOCIAL CARE

CBO's often offer services that address many of the social needs of the individuals that they serve. This can align with the positive health outcomes associated to social determinants of health.

Examples include:

- A CBO that provides transportation support to individuals to facilitate their ability to access medical care and other community services may find that their service recipients see fewer hospitalizations.
- A CBO that helps individuals with long-term care needs locate and retain housing may find that stable housing can help people focus on other health needs, such as preventative or chronic care.

As a CBO that provides care in the community, consider how your work impacts both health and social outcomes.

REIMBURSEMENT FOR SOCIAL DETERMINANTS OF HEALTH (SDoH)

In 2019, a new CMS rule allowed Medicare Advantage plans to offer supplemental health-related benefits to members. These services can include adult day care, personal care, home delivered meals, caregiver support, and more. CBOs may be providing exactly these kinds of support services under other funding sources. Identify Medicare Advantage plans in your area as potential new business. This CMS site provides a search for plans: https://www.medicare.gov/find-a-plan/questions/home.aspx.

for Medicare and Medicaid Services (CMS) is increasingly creating structures and policy changes that allow payers to pay for SDoH. Work with your business partners and potential payers to understand the issues they monitor and explore how your services can improve their performance rates and overall costs.

Connect Services to Outcomes

The Driver Diagram found in **Step 2: Plan** can be used to develop strategies to help address payer needs. In this model, you will take the need or desired outcome as you understand it and break it down in such a way that you identify a specific solution (via your services) that when implemented will address the need. A solution to a problem creates value.

You may also draw a simple cross-walk that connects the payer's challenges, needs and desired outcomes with your known strategies or solutions. Table 2: Connect Services to Outcomes can help you connect common payer needs with services your CBO provides along with the impact or 'value-add' of those services. Conduct this exercise with all the potential payers you have in mind.

Table 2: Connect Services to Outcomes

Potential Payer Needs or Outcomes	CBO Service	Service Impact
Consumer satisfaction		
Consumer engagement		
Community integration		
Employment placements		
Improved length of employment		
Improved health		
Reduced hospitalizations or nursing facility stays		
Reduced emergency room visits		
Reduced health and safety incidents		
Cost savings		
Improved ability to keep appointments		
Prompt initiation of services		
Improved performance on quality measures (e.g. NCI™, NCI-AD™, HEDIS®)[3, 4, 5]		
Improvements to Social Determinants of Health (SDoH)		

Each payer will perceive the value of your services differently based on how well they understand your organization. Some may not understand the service you or other CBOs provide. Others may not be aware of the full spectrum of how your work impacts the consumer. A well thought out and clear value proposition can fill this knowledge gap, and eliminate bias or correct misperceptions. It is important to articulate this for each potential payer.

[3] National Core Indicators (NCI). https://www.nationalcoreindicators.org/
[4] National Core Indicators—Aging and Disabilities (NCI-AD). https://nci-ad.org/
[5] Healthcare Effectiveness Data and Information Set (HEDIS). https://www.ncqa.org/hedis/

Measure outcomes and use data to articulate your business case

Once you identify the value your organization brings to potential payers, you will want to quantify, or prove, that value. Use both quantitative and qualitative information about the impact of your programs to illustrate the success of your programs to potential payers and providers. Qualitative information may include facts about the current experience of the individuals you serve; their goals and desired outcomes; and how your services support the goals and outcomes of the organization you want to work with.

QUANTITATIVE VS. QUALITATIVE

Quantitative Data:
Information that is numerical in nature. This type of data can be used in statistical analysis.

Qualitative Data:
Information that is gained through observation. This type of data is non-numerical in nature, but characterizes elements that occurred during observation.

Quantitative information such as data about the utilization of health, behavioral and supportive services, and how your services impact that utilization is important for payers of health services to see and understand. Payers may be interested in how your services reduce utilization of some services such as emergency room visits, increase utilization such as improved medication adherence rates or help a person remain stable in their community. As the provider of service, you will need to identify how you can capture, analyze and share that information.

Identify ways that your organization can use data to improve your services as well. If health payers were to share data with you, how could your organization better serve the person? Explore these concepts with payers as a way to develop solutions that positively impact the consumer, your organization and the payer.

In Table 2: Connect Services to Outcomes, you identified how the services you provide can impact a potential payer's needs or desired outcomes. Next, identify the data you need to demonstrate your effectiveness, where that data may be found and how it is tracked.

The use of quantitative data is important in a competitive environment; however, it only tells a part of the story. Qualitative data can be used to add context to what is seen in facts and figures. Leverage your knowledge of current experiences in the field to help MCOs understand how your work impacts outcomes. For example, an increase in utilization may be due to a change in referral patterns and services being provided to individuals with more complex needs; whereas a decrease in utilization may be the result of decreases in referrals, improvements in programming, effective management and delivery of supports. As the provider of services, you must tell the story and help those you work with understand what you are doing and how it impacts the delivery of care.

Table 3: Use Data to Demonstrate Outcomes

Potential Payer Needs or Outcomes	CBO Service	Impact of the Service to the Payer	What is the Evidence?	Where is the Data?
Consumer satisfaction				
Consumer engagement				
Community integration				
Employment placements				
Improved length of employment				
Improved health				
Reduced hospitalizations or nursing facility stays				
Reduced emergency room visits				
Reduced health and safety incidents				
Cost savings				
Improved ability to keep appointments				
Prompt initiation of services				
Improved performance on quality measures (e.g. NCI™, NCI-AD™, HEDIS®)				
Improvements to Social Determinants of Health (SDoH)				

Finally, your value proposition might address the requirements of a potential payer. For example, in Medicaid programs, the state and MCOs are required to report on certain consumer satisfaction, engagement, and quality measures. In these cases, part of your value statement should include a description of how your organization can help meet those requirements. Similarly, MCO's may ask you to describe the evidence-based practices you use in your programs. Evidence-based practices rely on scientific evidence and data to inform decision making. MCOs are required to contract with quality providers and often look to the use of evidence-based practices as a means to document that quality. One advantage of using evidence-based practices is that you may be able to point to national data about efficacy as you make your pitch about the value your services add.

Expand your Value Proposition through Collaborative Partners

Collaborative partners include groups, organizations, associations or others in the local community, region, or state who understand the benefits your business brings to the community. Collaborative partners have the potential to improve your value proposition as they can enhance services offered, expand your service area, or improve organizational stability with opportunities to share in administrative costs. It is not uncommon that a partner will play multiple roles at different points in the relationship.

COMPLEMENTARY:
Different but related services are provided.

SUBSTITUTION:
Same or similar services combine or merge to expand the reach or capacity of existing services.

In **Step 1: Prepare**, you identified potential community partners and the role each may play in the business objectives of your organization. You also explored how you might develop a mutually beneficial relationship. Now that your strategy is clear, and you better understand both your needs and the needs of the payers you seek to work with, re-evaluate this list and update it accordingly.

For example, in your review of payer needs, you may have identified needs that your organization is unable to fulfill on its own. In this case, consider a partnership with an organization(s) who complements your services or augments your capacity. A "complementary" partner expands the menu of services that can be offered to a potential payer. A "substitution" partner offers the same or similar services, which helps both of your organizations expand the reach or total capacity of services provided. In both of these situations, the relationship increases the value you offer to the potential payer. The types of partners you need to add will depend on the potential payer's needs.

An example of a substitution partnership are Centers for Independent Living (CILs) and/or Area Agencies on Aging (AAAs) who partner to form a statewide Aging and Disability Resource Center (ADRC) network. An

example of a complementary partnership is one where an Intellectual and/or Developmental Disability (I/DD) agency partners with a CIL to provide training in independent living skills to young people as they transition out of high school.

Collaborative relationships can be simple or complicated. They might simply require an agreement where the role of each organization is made clear, whereas other relationships might join the organizations together more formally. A merger happens when two organizations decide to come together to form a completely new entity. In an acquisition, one organization takes over another organization. The acquiring organization continues to exist while the acquired organization does not. Both are legal changes in the organization's structure and finances.

Mergers and acquisitions can broaden the range or improve the quality of services of the participating organizations. If an organization is stressed, a merger or acquisition can stave off financial duress or improve operational controls.[6] If you seek to establish a formal relationship with a collaborative partner, be sure to seek legal counsel in order to ensure that the scope and boundaries of the relationship are clear and that all parties are appropriately protected.

[6] "How to Save a Nonprofit: The Care Steps Required in Mergers and Acquisition." Non-Profit Quarterly. June 20, 2017.

MARKET AND NETWORK

Once you have identified the payers you want to work with and developed your value proposition, you are ready to develop your marketing strategy. CBOs sell very specific services to a targeted audience that have a fundamental need for those services in order to improve their quality of life and independence. The goal is to focus your resources on this target audience and those who serve them.

Relationships are a primary avenue that your organization can use to market its services. Leverage your professional network to spread the word about your organization and your value proposition. The champions you identified in **Step 1: Prepare** can now help connect you to key people or organizations. For example, a champion who is active in the local chamber of commerce can connect your organization to key partners that are also active in the group, like a hospital association, representatives from a regional MCO, and state advisory boards related to aging or disability services.

Connect with the right people

It can be difficult to identify the "right" people when you first establish relationships with a new payer. Because of this, consider every person you meet from the payer side as one of the "right" people. Everyone has a role to play. MCOs have clinical departments, provider relations and contract departments, administration and so forth. Each will be concerned with a different aspect of your organization. Clinical staff will be concerned about how well your services meet the needs of the people they serve; provider relations staff will be concerned about how well you are able to meet the terms of the contract; and administration staff will be concerned about how the services you provide fit into the overall goals of the organization. Each function is important and each person at the MCO can introduce you to another person in another role. Do not underestimate the importance of the relationships at all levels of the organization.

Ultimately, you want to find the person who makes decisions regarding whether or not they will contract with you. To find the decision makers at the organization you seek to work with, ask questions such as:

- Who makes decisions regarding contracting?
- Who handles business development for your organization?
- Who controls the budget?

An in-person meeting with leadership is optimal but may not be necessary or attainable.

Share your Value Proposition

The information you relay in your very first meetings should be succinct. Outline your organization's mission, the services you provide, the value of the services to the payer, and the prospect to build a mutually beneficial partnership in an 'elevator pitch' style. An elevator pitch is a short "sales pitch" that quickly and simply states your value proposition. Practice your pitch in both written and verbal communication with potential partners to increase your comfort level and the effectiveness of the message.

Table 4: Elements of an Elevator Pitch

Who are you? Describe your organization and its vision.
What do you do? One sentence description of your core activity/benefit.
How do you do it? Describe the model, method, intellectual property (IP), or differential your organization uses.
What do you deliver? Describe the outputs that can be measured as success.
Who do you work with? Describe the specific organizations that need what you offer.
How do you add value to the person/organization you are speaking to? Describe how you can quickly meet their needs.

Example 2: Example of an Introductory Letter can be used for introductions to potential partners. It should be customized with relevant CBO information.

Example 2: Example of an Introductory Letter

Dear [CEO/PRESIDENT OF PARTNERSHIP GROUP],

Hello. I am writing to introduce myself and my business to [POTENTIAL PARTNER]. I would like to discuss the opportunity for a mutually beneficial partnership and am interested in scheduling an in-person meeting at your earliest convenience.

I understand that [PLACEHOLDER FOR BRIEF INFORMATION ABOUT POTENTIAL PARTNER]
We are [PLACEHOLDER FOR BRIEF CBO HISTORY AND MISSION]

We offer [PLACEHOLDER FOR DESCRIPTION OF CBO SERVICES]

We believe there is a great opportunity for both our organizations to advance our objectives in better serving the residents of our community and state. We would like an opportunity to better understand your organization's objectives and to discuss how our services can meet your needs. I will follow-up with a phone call to schedule an appropriate time to discuss these issues in greater depth. Thank you for your time and consideration. We look forward to connecting in the future.

Sincerely,

Once a meeting is secured, you will need to prepare. Use Table 5: From Knowledge to Action to collect all that you know about each of the potential payers that you are meeting with. Use this information to prepare for your presentation or pitch and update it as you continue to learn and gather information about each potential payer.

The primary objective of the initial in-person meeting with the potential partner is to determine if a future relationship can be cultivated. Agenda items to address during this meeting include: the reason for the partnership, proposed outcomes, perceived advantages, cost of working together, the value of your CBO, and roles and responsibilities.

Table 5: From Knowledge to Action

Target:			
Possible target population(s)	Defining characteristics		
The primary needs of the target population that our organization can address:			
Measurable high value outcome our organization can produce for the target population:			
Payer we will pursue first/next (e.g., health plan, ACO, health system, etc.)			
Name and type of payer	Its mission and major interest(s)/need(s)		
Key person to engage for contracting			
Barriers to securing a contract (e.g., policy, regulatory condition(s), etc.)			
Our next step to further engage the contracting organization			
Champions who will endorse our network and open doors			
Name of champion	Organization	Who will make contact	Which target population/payer
#1.			
#2.			
#3.			
Competition and forces that we will need to address (Competition could include other CBO's, health care entities, etc.)			
Primary competitors	Major source of inertia we must overcome		Competitor's advantage vs. our advantage
Action step(s) we will take in the next few weeks to improve our position in the market:			

Ask questions and listen to the issues that are identified by the potential partner and consider how your organization can address these issues. It is important to listen carefully to what is being said by the potential payer. Identify issues of importance to your contact. Common interests or goals can connect your two organizations. If nothing else, a clear understanding of what is important to the potential partner or payer may help drive future communication and/or modify your business strategy. This may also be an opportunity to help inform the potential payer about unknown issues of importance to your organization.

When it comes time to present your information to the potential new payer, be prepared. Show that you understand them, their role, their organization and who they serve.

Be concise — Communicate necessary information but avoid unnecessary length. The longer your message, the greater the odds you will lose your audience.

Be clear — Be clear and communicate information about your organization and about what you want from or are offering to the payer. Do not force your potential payer to guess or assume what your intentions are.

Answer the question "why me?" — Find a way to address the "why should I be interested?" question for your potential payer to help them understand what sets your opportunity (and organization) apart from the rest.

Leave an action item — Close with an actionable request (i.e. "let me know what your availability looks like in the next few weeks"). Close strong!

Follow-up — Following up every so often increases the odds that you will ultimately catch someone at a good time. If an email message is sent, follow-up with a phone call.

EXECUTE AN AGREEMENT

If your outreach and value proposition to the potential payer was successful, it will be time to decide whether or not to enter into a contract with that payer. A contract is established when two parties legally consent to a set of terms. All contracts, regardless of the content, will contain the four following elements: consideration, legal purpose, capable parties, and mutual assent. These four basic elements create an outline of agreements between parties as well as provide legal protection in enforcing the terms. Effective contract procurement and management is now a core competency CBOs need to have.

Figure 4: Standard Contract Elements

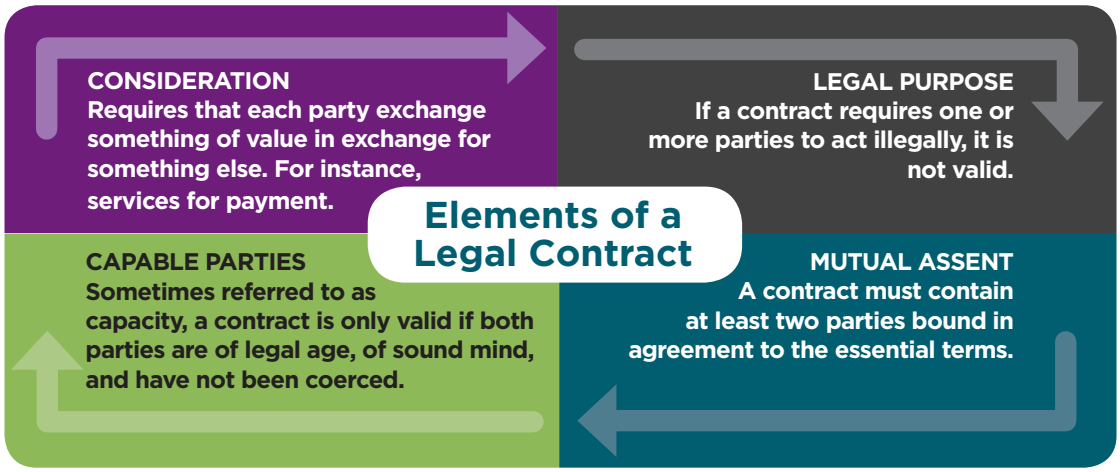


Figure 5: Standard Contract Sections shows typical sections found in a contract: standard terms and conditions, statement of work, and termination clauses. Specific details to pay attention to within the contract include performance requirements related to each party, costs to be paid by each party, and the timeline for the agreement.

Figure 5: Standard Contract Sections

Standard Terms and Conditions

- Should protect your business
- Should be designed to ensure parties understand the liability both parties accept by entering into the agreement

Statement of Work

- Specifies all the criteria that will be fulfilled between the parties
- Will contain:
  - requirements
  - project milestones
  - deliverables
  - services
  - evaluation criteria
  - technology requirements
- Note the requirements your organization will need to meet

Termination Clauses

- Explains what occurs when one or both parties fail to uphold the terms and conditions of the agreement
- Includes process for conflict resolution
- Notes whether or not there is an opportunity for mediation

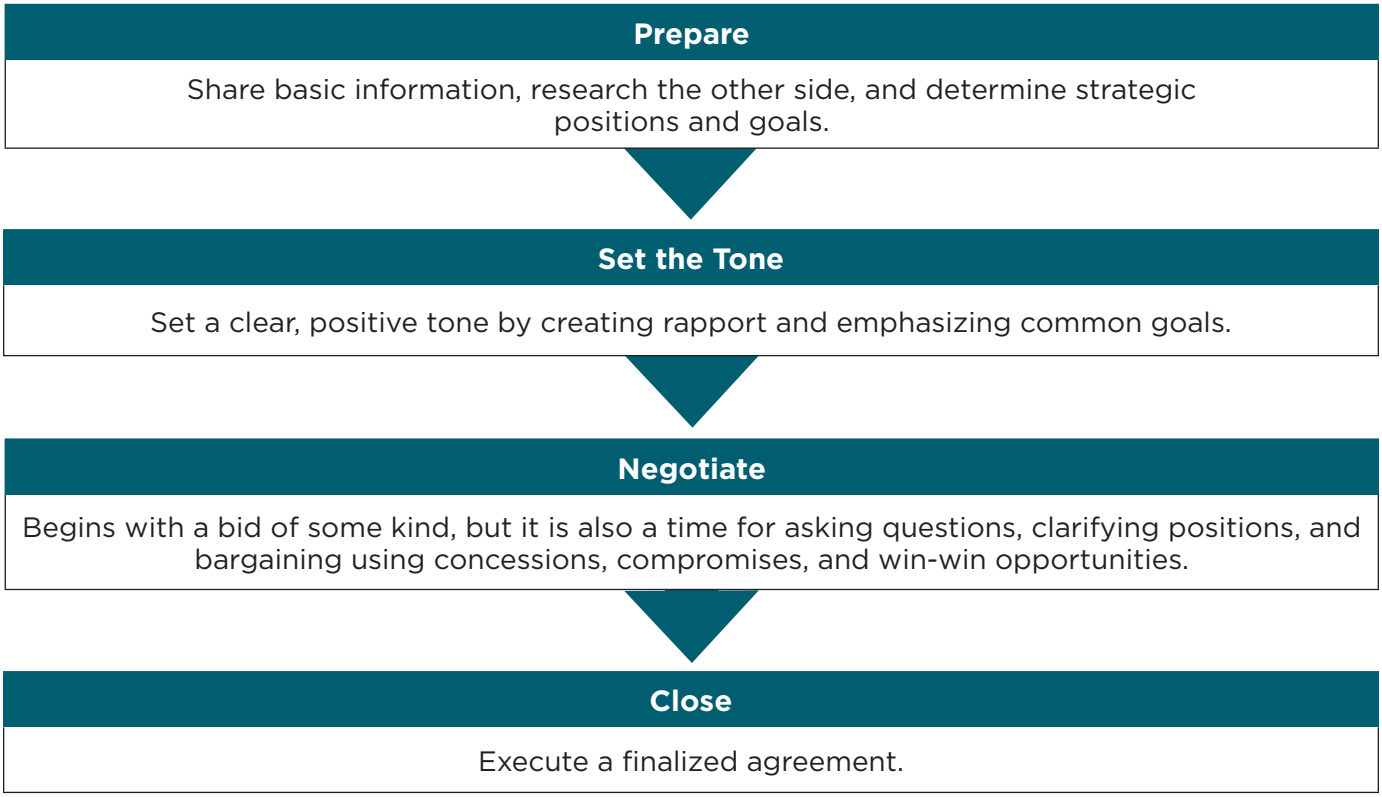
The prospect of an agreement is an exciting time as you have worked hard to get to this point. However, do not agree to terms or sign an agreement too quickly. In negotiation and execution of an agreement, there will be many factors to consider:

- Covered/funded services.
- Contract and operational requirements.
- Reimbursement rates.
- Timeliness of payments.
- Return on Investment.
- Historical relationship with providers.
- Quality of services/reputation.
- Consumer satisfaction.

The Negotiation Process

You may not realize it, but your research on your potential payers or partners and possible reimbursement structures has given you a head start on the negotiation process. This information provides you insight into what the payers want and need and what you want and need in return.

Figure 6: Negotiation Process



Most CBOs have little to no experience negotiating and contracting with payers. Many CBOs are simply accustomed to being told what a service is worth by their funder. Negotiations with integrated care entities such as MCOs, health care systems and other potential partners is a particularly fresh field. To complicate the matter, some health plans may not know how

to negotiate or contract with CBOs either. Regardless of your experience, in today's competitive environment, it is critical that you negotiate positive contractual terms to maintain your daily operations and grow your business.

Outline Negotiation

There are several models and tools that can help organizations develop negotiation strategies. We will discuss two of these — an Outlining Negotiation Targets tool and a Negotiation Canvas. Together they can help you walk through the negotiation process. The Outlining Negotiation Targets tool is used to prepare for a negotiation, while the Negotiation Canvas is used to understand both sides' positions during negotiations and document decisions.

The Outlining Negotiation Targets tool provides a space and reference point for your organization as you identify the objectives for negotiation in three categories: price, quality, and value. Use the tool to both prepare for the negotiation and to document outcomes that occur during the negotiation. To prepare, anticipate the decision points of the outcomes that may occur during the negotiation discussion. Create targets for each negotiation topic to determine the criteria you need to create win-win scenarios, areas of compromise, concession, or walk away points.

NEGOTIATION TERMINOLOGY:

- **Win-win** — Outcome that benefits both sides, often born from discussing common goals.
- **Compromises** — When both sides sacrifice their ideal outcomes for an agreed-upon outcome that is satisfactory for both parties.
- **Concessions** — Giving up a point that does not hold high value to one side but does hold high value to the other side.
- **Walk-away point** — A condition (often a price) that one cannot accept. Both sides will have walk away points. As long as the two are not mutually exclusive (e.g., one side will walk away from negotiation before paying the other side's minimum price) then the two sides will likely reach an agreement.

For example, a win-win scenario on payment terms may result in 30 days to invoice and 30 days before payment is due, an equal number of days for each party's position. If your CBO is accustomed to receiving reimbursement 15 days from receipt of claim, relaxing the terms of the contract to 30 days would be a compromise. If the contract states that reimbursement may occur as late as 90 days from receipt of claim and your organization does not have the reserves to pay staff timely for this length of time, then these payment terms would be a non-negotiable walk-away point.

Set your walk-away points before going into the negotiation, so that you have confidence in the criteria you need to make your business successful. You also need to be aware of rules and limitations that are placed on the payer. For example, the state may determine payment schedules for an MCO who in turn is not able to negotiate on the subject. In this case, be aware of the limitations and determine whether or not your organization can work in that environment.

If you anticipate the potential outcomes of the proposed terms of the agreement, you will be in a better position to pivot the conversation to reach your objectives. Whenever possible, have your team help you prepare for negotiation. The more perspectives you have on the contract terms, the higher the likelihood that you will identify any areas of weakness. It is well worth the time to think though possible outcomes that may jeopardize the sustainability of your organization before you sign a contract.

Table 6: Outlining Negotiation Targets Tool

Outlining Negotiation Targets				
Negotiation Items	Win-Win	Compromise	Concession	Walk-Away
Price				
Unit of service				
Anticipated volume				
Payment terms				
Requirements like licensure or accreditation				
Required documentation				
Required reports				
Required service initiation time				
Other quality measures				

Negotiate Rates

In **Step 2: Plan**, you learned to evaluate the return on investment (ROI) of various strategies. When presented a proposal, be sure to calculate the ROI for the specific offer/contract you are considering. Your ROI calculations will be more accurate with the specific information you now have. Information about administrative requirements that will result from the proposed contract arrangements, such as billing, reporting, documentation, and any licensure or accreditation requirements along with the contract rates themselves will all impact your potential ROI.

During the contract negotiation you will review and make different reimbursement proposals. The rate structure, the methodology, the unit of service, and the rate itself may be subject to negotiation. A break-even analysis can help you evaluate the different options being considered. Example 3: Example of a Break-Even and Profit Analysis under Different Rate Structures provides a structure to conduct this analysis.

You will want to be very aware of your breakeven point. That is, you will want to know exactly how much it costs your organization to deliver the service being negotiated and how that compares to the reimbursement the payer has offered. If you have appropriately cost allocated as discussed in **Step 3: Stabilize**, you should have the financial information you need to make that calculation. Be prepared to walk away from contracts that are not profitable for your organization.

Example 3: Example of a Break-Even and Profit Analysis under Different Rate Structures

Proposal	Fee schedule — hourly rate	Fee Schedule — daily rate
Unit of Service	**hour**	**day**
Unit Rate	$100	$525
Anticipated Monthly Volume	15 consumers receiving an average of 5 hours per day = 15 x 5 x 30 = 2,250 hours	15 consumers receiving an average of 5 hours per day = 15 x 30 = 450 days
Total Proposed Payment	$225,000 ($100 X 2,250)	$236,250 ($525 x 450)
Your Variable Costs (assume $80 per hour)	$180,000 ($80 x 2,250)	$180,000 ($80 x (15 x 5 x 30))
Contribution Margin (payment minus variable costs)	$20 per hour (($225,000 - $180,000)/2,250)	$125 per day (($236,250 - $180,000)/450)
Fixed Costs	$10,000	$10,000
Breakeven Point	500 hours ($10,000/$20)	80 days ($10,000/$125)
Profit	$35,000 (19.86%)	$46,250 (23.77%)

The hourly rate is straight forward to calculate. The daily rate is a bit more complicated. You need more information about service utilization. The average number of hours per day is a critical piece of information. That introduces a new variable that will impact your bottom line. Example 4: Example of a Break-Even and Profit Analysis under Different Volume Structures (daily rate) shows what happens when that average changes, either up or down, with the daily rate.

Example 4: Example of a Break-Even and Profit Analysis under Different Volume Structures (daily rate)

Proposal	Fee Schedule — daily rate	Fee Schedule — daily rate
Unit of Service	day	day
Unit Rate	$525	$525
Anticipated Monthly Volume	15 consumers receiving an **average of 4 hours per day** = 15 x 30 = 450 days	15 consumers receiving an **average of 6 hours per day** = 15 x 30 = 450 days
Total Proposed Payment	$236,250 ($525 x 450)	$236,250 ($525 x 450)
Your Variable Costs (assume $80 per hour)	$144,000 ($80 x (15 x 4 x 30))	$216,000 ($80 x (15 x 6 x 30))
Contribution Margin (payment minus variable costs)	$205 per day (($236,250 - $144,000)/450)	$45 per day (($236,250 - $216,000)/450)
Fixed Costs	$10,000	$10,000
Breakeven Point	48.78 days ($10,000/$205)	222.22 days ($10,000/$45)
Profit	$82,250 (34.81%)	$10,250 (4.33%)

Example 5: Example of a Break-Even and Profit Analysis under Different Volume Structures (hourly rate) shows what happens when the average changes, up or down, with an hourly rate.

Example 5: Example of a Break-Even and Profit Analysis under Different Volume Structures (hourly rate)

Proposal	Fee Schedule — hourly rate	Fee Schedule — hourly rate
Unit of Service	hour	hour
Unit Rate	$100	$100
Anticipated Monthly Volume	15 consumers receiving an **average of 4 hours per day** = 15 x 4 x 30 = 1,800 hours	15 consumers receiving an **average of 6 hours per day** = 15 x 6 x 30 = 2,700 hours
Total Proposed Payment	$180,000 ($100 X 1,800)	$270,000 ($100 X 2,700)
Your Variable Costs (assume $80 per hour)	$144,000 ($80 x 1,800)	$216,000 ($80 x 2,700)
Contribution Margin (payment minus variable costs)	$20 per hour (($180,000 - $144,000)/1,800)	$20 per hour (($270,000 - $216,000)/2,700)
Fixed Costs	$10,000	$10,000
Breakeven Point	500 hours ($10,000/$20)	500 hours ($10,000/$20)
Profit	$26,000 (14.44%)	$44,000 (16.3%)

The profit margin with the daily rate is certainly more volatile with changes to the average hours used per day than the hourly rate is. This is just an example of the many factors you need to consider when you evaluate reimbursement proposals. In addition, keep in mind the following:

- Are there requirements for reporting or licensure or accreditation, etc. that will add to your current fixed and variable costs?
- Sometimes significant increases in volume will cause your fixed costs to increase. Is the volume of your new contract likely to create a situation like that?
- Do you have costs that regularly increase, such as cost of living wage adjustments or pending increases to minimum wage that will result in high personnel costs? If so, how does the timeline compare to the duration of the contract?
- Does your organization have the capacity for increased volume? What growing pains do you expect? Will they impact the quality of services, i.e. your ability to meet contract obligations?

In addition to ROI, evaluate potential impacts to cash flow. Timeliness of payments is an important issue to understand. If reimbursement for services takes longer than your organization is accustomed to, you will need to determine whether or not you have enough money in reserves to cover the extended period or if you will need to secure a line of credit to manage cash

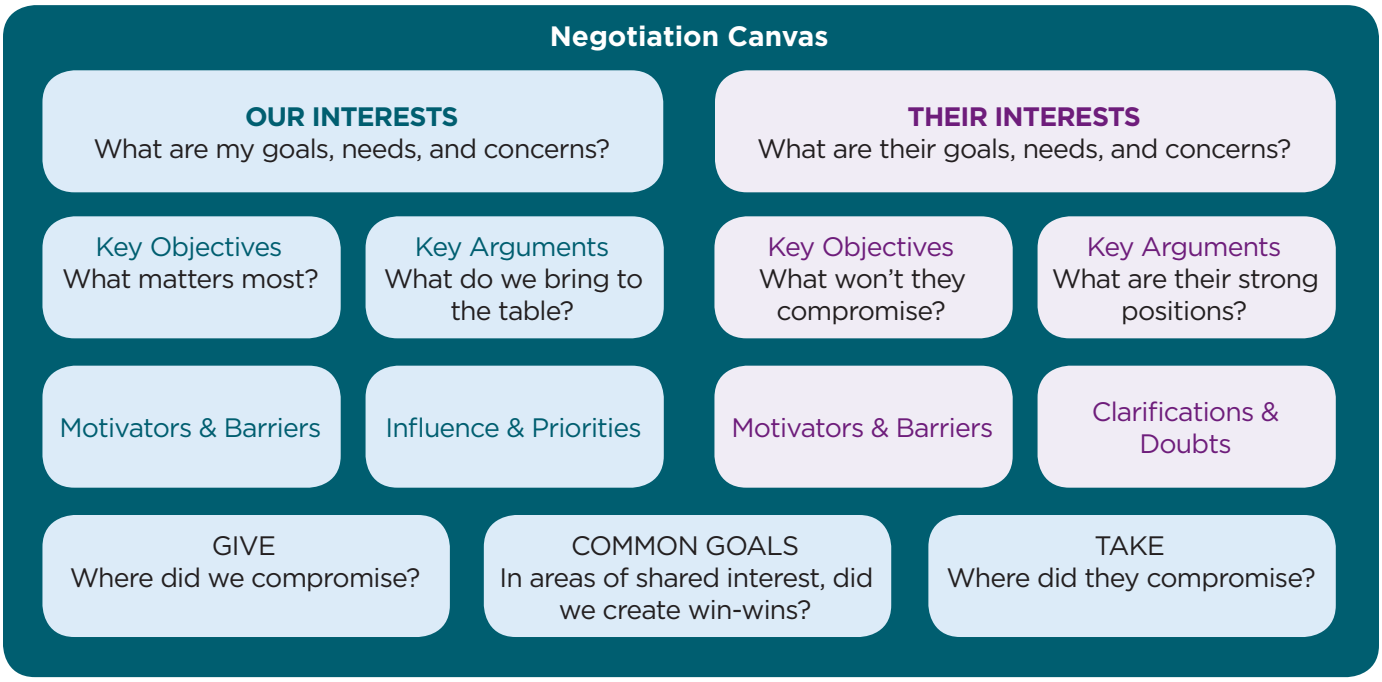
flow. For MCOs, you can obtain information from the contract staff at the organization you seek to contract with, the proposed contract they send to you, or through a review of the state's contract with the MCO.

Negotiation Canvas

The Negotiation Canvas tool provides explicit concepts to track both sides' positions during a negotiation. Keep in mind that the canvas is not meant to be a puzzle. If a counterpart's interests, motivators, or objections are unknown, simply ask what they are. If interests are not shared, it will be more difficult to reach win-win scenarios. The canvas should follow the flow of the conversation during the negotiation. For example, when the negotiation begins, each side should share their interests. Either party can lead. If the other side is reluctant to share their interests, then pivot the conversation to discuss motivations and barriers. Articulate your objective and the arguments for why your objectives are obtainable. Pay close attention to any doubts that come from the other side, as those doubts may not allow you to reach key objectives. Classify each point during the negotiation in the canvas; the ability to identify what is holding the negotiation back or driving it forward will help you tailor your response to meet your organization's objectives.

The canvas ends with a summary of what each side conceded, gained, and agreed to. After the negotiation, document what occurred during the process in order to capture any lessons learned. For example, if a position was conceded, you may be able to develop talking points for future negotiations that address potential barriers. If win-win scenarios were achieved, you may be able to lead with that argument in future negotiations.

Figure 7: Negotiation Canvas



CONCLUSION

The ability to grow and develop your organization begins from a solid foundation. The more stable your organization is, the better the partner you will be to new payers. Strategic plans are not static. Continually evaluate your objectives and your progress in meeting goals. **Step 5: Monitor, Evaluate and Respond** will walk you through methods you can use to keep your organization on track.

RESOURCES

The HCBS Clearinghouse (hcbs.org) contains resources about the development of business relationships between community-based organizations that serve persons with disabilities and health plans and other integrated health services. To explore more resources related to business acumen for disability organizations, visit hcbs.org and conduct a keyword search for the topic you are interested in or use the general term “business acumen” to see all related topics.

APPENDIX

The following templates can help you and your team document your findings and ideas as you grow and develop your organization:

- Outcomes, Service and Data Cross-Walk
- Elevator Pitch Template
- Knowledge to Action Tool
- Outlining Negotiation Targets Tool
- Break-Even and Profit Analysis Tool

Business Acumen for Disabilities Grant

The Business Acumen for Disabilities Grant is provided by the Administration for Community Living (ACL) to ADvancing States in collaboration with national partners.[7] The HCBS Business Acumen Center is dedicated to providing resources to sustain disability organizations. To learn more, visit hcbsbusinessacumen.org

[7] Grant Partners include: ADvancing States, American Association on Health and Disability (AAHD), American Network of Community Options and Resources (ANCOR), MERCER Health & Benefits, National Association of State Directors of Developmental Disabilities Services (NASDDDS), National Council on Independent Living (NCIL), National Disability Rights Network (NDRN), Sage Squirrel Consulting, and the University of Minnesota — Institute of Community Integration.

Outcomes, Service and Data Cross-Walk

Potential Payer Needs or Outcomes	CBO Service	Impact of the Service to the Payer	What is the Evidence?	Where is the Data?
Consumer satisfaction				
Consumer engagement				
Community integration				
Employment placements				
Improved length of employment				
Improved health				
Reduced hospitalizations or nursing facility stays				
Reduced emergency room visits				
Reduced health and safety incidents				
Cost savings				
Improved ability to keep appointments				
Prompt initiation of services				
Improved performance on quality measures (e.g. NCI™, NCI-AD™, HEDIS®)				
Improvements to Social Determinants of Health (SDoH)				

Elevator Pitch Template

Who are you? Describe your organization and its vision.
What do you do? One sentence description of your core activity/benefit.
How do you do it? Describe the model, method, intellectual property (IP), or differential your organization uses.
What do you deliver? Describe the outputs that can be measured as success.
Who do you work with? Describe the specific organizations that need what you offer.
How do you add value to the person/organization you are speaking to? Describe how you can quickly meet their needs.

Knowledge to Action Tool

Target:	
Possible target population(s)	Defining characteristics
The primary needs of the target population that our organization can address:	
Measurable high value outcome our organization can produce for the target population:	

Payer we will pursue first/next (e.g., health plan, ACO, health system, etc.)	
Name and type of payer	Its mission and major interest(s)/need(s)
Key person to engage for contracting	
Barriers to securing a contract (e.g., policy, regulatory condition(s), etc.)	
Our next step to further engage the contracting organization	

Champions who will endorse our network and open doors				
Name of champion	Organization	Who will make contact	Which target population/payer	
#1.				
#2.				
#3.				

Competition and forces that we will need to address (Competition could include other CBO's, health care entities, etc.)		
Primary competitors	Major source of inertia we must overcome	Competitor's advantage vs. our advantage
Action step(s) we will take in the next few weeks to improve our position in the market:		

Outlining Negotiation Targets Tool

Outlining Negotiation Targets				
Negotiation Items	Win-Win	Compromise	Concession	Walk-Away
Price				
Unit of service				
Anticipated volume				
Payment terms				
Requirements like licensure or accreditation				
Required documentation				
Required reports				
Required service initiation time				
Other quality measures				

Break-Even and Profit Analysis Tool

Proposal		
Unit of Service		
Unit Rate		
Anticipated Monthly Volume		
Total Proposed Payment		
Your Variable Costs		
Contribution Margin		
Fixed Costs		
Breakeven Point		
Profit		

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