

Negotiating Risk-Based, Performance Based Contract; An Overview of Internal and External Issues

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INTRODUCTION AND PRIMARY ISSUES

Entering into risk-based performance based contracts requires sophistication on the part of the negotiator. It requires that the roles of all parties involved be clearly defined, that the expectations for performance be very specifically described and it requires that any opportunity to for misconstruing intent be discussed and clarified. This paper has been developed to provide a set of guidelines to assist the community-based provider in negotiating contracts.

First, it is important to make a distinction between contracts being negotiated. The first negotiation involved in the development of an Integrate Delivery Network is with IDN partners. This process of negotiation requires clarifying mission and governance structure, decision-making processes, clinical approaches, and risk management strategies. It also involves the complex process of clarifying the position of the network and individual members on competition.

The second negotiation is with the purchaser. This negotiation surrounds the issues of risk, incentives and sanctions, access, quality assurance and reporting requirements. In many ways the latter is much less complicated that the former. This paper will address both aspects of negotiation.

SECTION I NEGOTIATION WITH MEMBERS OF THE NETWORK.

Integration of the administrative infrastructure and services of multiple community agencies with diverse cultures, leadership styles, and financial assets is both exciting and tremendously challenging. If the process of development is done thoroughly, IDN members should expect that there will be challenging, thought provoking and even tense discussions. As such it is critical that the IDN have at its helm, a leader who understands the market and is skilled at negotiation, consensus building, and making rapid changes to adjust to market shifts. This leader, whether informally or formally appointed by the group, can expect to become the target of the frustration and anxiety of the group. One provider network leader in the northeast had this to say, "People do not want to lose power. Accept that. Integration of clinical decision-making and financing and the development of a single data source will result in individuals experiencing a loss of control. As this begins to occur, members of the network will look for a scapegoat. The leader needs a thick skin and strong sense of mission if he/she is to survive. Don't enter this process expecting to be popular."

A study of IDNs around the country teaches us that some of the tension and strife can be avoided by making a commitment to deal with the tough issues upfront in a planful manner. We know that it is much easier to work through issues and find consensus when emotions are not rocked by crisis. It is strongly recommended that IDN members spend time early in the process negotiating the following areas:

- A) Governance Structure and Decision Making Process
- B) Business Purpose
- C) Philosophical Orientation to Service Delivery
- D) Referral Process
- E) Competition

A) Negotiating the Governance Structure and Decision Making Process

Emerging community-based provider networks must be clear about their decision-making processes. Many fledgling groups attempt to make initial decisions through the process of management by committee or a consensual decision-making model because this is in keeping with the values of the community stakeholders. This process may become very complicated due to the personalities and the issues of control and turf. Leaders of individual agencies are frequently powerful, controlling individuals. These very traits may have contributed to their success in the past, but they may not promote strong team play. A group of powerful individuals can make consensus management virtually impossible. A strong group facilitator will be required to navigate the early waters of group development and early decision-making.

The first phase of developing a governance structure is to explore the variety of governance options that exist. These options range from very formal legal structures with membership fees tied to voting power, to loose agreements between participating community agencies that contribute in-kind resources and minimal money to gain access to the right to vote. Woven throughout this discussion is how the consumer, the private citizen and the very small or informal service provider will be incorporated into the governance structure. Tension may arise around control over the voting process. A true community service network will not make the cost of membership and the right to vote prohibitive, but ensure that all willing participants can vote. However, this approach may be in conflict with community agencies that want to maintain control over market share. It is recommended that a sub-committee of providers and consumers be established to research the pros and cons of the many options that exist. This research should also include the impact Canon law has on each of these structures. Once the structure is determined the bi-laws must be established. For the purpose of negotiation, the bi-laws must contain at a minimum:

- ◆ Structure and makeup of the board of directors.
- ◆ Roles, authority and responsibility of board members—including how will hire/fire the CEO.
- ◆ Rules for voting, quorum requirements, etc.
- ◆ Process for replacement of board members.
- ◆ Description of the issues for which the board has authority. (Note that in any new organization the board's role is more hands on during the first phases and as time evolves and the organization is running smoothly, the board's role shifts to policy, visioning and development.)

B. Negotiating the Common Business Purpose

Community agencies will enter these IDNs for many reasons. Some to survive, some to gain power, some to gain a larger share of the service market and some to find a means *not* to have to change the way they do business. The IDN needs to lay these issues on the table and develop a business plan that requires a commitment to a certain vision of growth and entrepreneurial activity. Critical issues that must be negotiated include:

- ◆ What populations does the IDN want to serve—child welfare, elder services, mental health, individuals with disabilities?
- ◆ Does the IDN plan to compete for public, private pay and insurance sector business? How does pursuing the commercial sector and private pay markets align with the mission of the network members?
- ◆ Are individual members comfortable with revenue in excess of expenses? Do they plan for this? If so how much? (These are value-laden discussions).
- ◆ Are members willing to invest their own money to market and secure the business?
- ◆ Are all members comfortable with sharing financial risk?
- ◆ If so, how much? Where does their individual boards stand on risk sharing arrangements?
- ◆ Information technology requires money—but is absolutely critical to survival in risk-based, performance-based environments. Who will own the Information System? If it is the network, what happens if the network dissolves? Who owns the data? Are all network members willing to fund the cost of the system?

C. Negotiating the Philosophical Orientation to Service Delivery

The establishment of a common mission for service delivery is a defining component of an integrated service network. While related to business purpose it is broader and defines the values of the entity. Once the establishment of the mission is complete, the next task of the network members is to determine the philosophical orientation and clinical model of service delivery. These decisions guide clinical protocol or “best practice” network provider credentialing, consumer involvement, cultural responsiveness and financing decisions. Many community-based provider networks developing across the country are minimizing the criticality of this task. They do not understand how practice orientation directly impacts financial/risk management. As a result, clinical disconnected clinical decisions between providers ultimately cost the network considerable money and catch families in what we call a “mission collision”. It is strongly recommended that the following questions be addressed and the answers translated into best practice protocols for the network.

- ◆ Will the services be provided within a family centered framework?
- ◆ If so, how will this be operationalized?
- ◆ Will assessment and service delivery be strength-based and solution-focused?
- ◆ Do all members of the network believe that families should be partners in treatment planning? How will this be operationalized? Documentation?
- ◆ What is the role of the consumer of services in service planning,

- implementation and quality assurance?
- ◆ How will the families' natural supports be utilized?
- ◆ How will the system ensure cultural responsiveness?
- ◆ Do families have a say regarding the type and duration of services?
- ◆ If some providers have clinical tendencies to ignore or relegate the family to a minimal role in case planning and service delivery, how will this be addressed? (This is both a financial and clinical issue.)

Often a common mission and values serve as the basis for gathering around a table. However, it is when these values are translated into practice that the proverbial "rubber meets the road."

D. Negotiating the Referral Process

As you can imagine, the referral process takes on some interesting complexity when the referrals are directed by the new network. Who receives the referrals? Why? Let's say for example, that all network members put in \$10,000. to fund the development of the network and \$10,000. each subsequent year for infrastructure support until the network can be self-sustaining. Now, if the networks membership has been chosen because of geographic coverage, with some members living in much more populated areas than others, it is logical to expect a difference in numbers of referrals. If this occurs, is the funding strategy equitable? Those receiving a stream of new referrals may answer this differently than those who are only experiencing a trickle of new business.

Or in a more complicated scenario, what if the network is comprised of members who provide similar services in a common geographic area. Who determines which provider receives the referral? What are the case manager's guidelines for agency utilization? Some networks attempt to resolve this issues by suggesting that the provider with the best outcomes will receive the referral. This is very complicated during the first several years when the network is most vulnerable and there is basically *no* reliable outcome data. Others attempt to resolve this issue by rotation. This is often successful, but can mean that the provider chosen to serve the family, may be located some distance form the family. Other networks have resolved this by saying that we will use a three-tier decision tree first, the family decides. If the family cannot decide then service proximity to the family decides. If outcomes are tracked, this can help inform the consumer's choice. Negotiating answers to the following questions begins to frame the referral process.

- ◆ Is the fee structure the same for all members, regardless of their potential for referrals?
- ◆ If not geography, how will the case manager determine who receives the referral for services?
- ◆ What is the consumer's role in choosing their provider?
- ◆ How will provider outcomes inform choices?
- ◆ If a provider is not getting referrals from the network can they grieve the referral process? How?

E. Risk Management Strategies

Critical to the success of the IDN is the willingness of all providers within the IDN to move their staff from a traditional fee for service practice orientation to a risk bearing orientation. Line staff need to be exposed to a new way of thinking about service delivery. Under risk arrangements, where there is a fixed amount of money to serve clients case opening to case closure, every unit of service used goes in the “payable” side of the ledger rather than the “receivable” side of the ledger. Standard “six month” or “thirty day” residential care programs are replaced with an individualized approach to service delivery. Each consumer must receive no more, or no less than is needed. Communication, training and technical support needs to be offered to ensure that the “status quo” mentality is consistently challenged and the new model of tightly managed service delivery is introduced. Questions that need to be resolved include:

- ◆ What training will be provided to staff in the network member agencies to help them make the service shift?
- ◆ How often will supervisors from the various agencies meet to talk through practice issues?
- ◆ Who will authorize the services to the clients?
- ◆ If a case manager authorizes the services, who supervises the case manager?
- ◆ Will *all* services be prospectively authorized? If not which services will require prospective authorization?
- ◆ What happens if there is disagreement?
- ◆ Who will conduct the Utilization Review process?
- ◆ Will UR be random, for every case, or only for certain “trigger “ cases? If so what are the triggers?
- ◆ What is the grievance process? For providers? For consumers?

F. Negotiating the Issue of Competition

Creating an Integrate Delivery network creates a competitor. If IDN members are not aware of this going in, it will become glaringly obvious when the first Request For Proposal (RFP) is received that allows for *either* the network or the *individual members* to pursue the new business. It has been amazing to watch how quickly network members take off the “hat” of the network and put on the “hat” of their individual agency when this situation arises. This is not only understandable, but one might suggest that it is the CEO’s responsibility to first and foremost safeguard the solvency of their own organizations. While this sounds logical, it becomes complicated quickly. What if the state lets a RFP and one network member lives in a geographic area of the state that is not addressed in this RFP and thus is unable to bid independently on the proposal. **Yet** they do want to see their investment in the network pay off and feels strongly that the *network should* go after the bid. However, another member lives in the geographic area addressed under the RFP and his/her agency has the resources to successfully compete. Who should bid on the proposal? How is this decided? Can a member compete against its own network? These issues, if not discussed and negotiated upfront can be the downfall of a network down the road. Given this reality these are the questions that need to be negotiated upfront:

- ◆ In what circumstances will the network bid on business? Only those where a network is required? All possible new business opportunities? Only those circumstances where the members are given first right of refusal?

- ◆ In what circumstances can an individual member compete against the network? How will it be decided if the situation falls into this category if the parameters are “gray”?
- ◆ Given the fact that the members will be using the network information system, can this system be referenced in a competitive bid?

In some ways the answer to this dilemma could be partially resolved by making certain that the IDNs business purpose is very clear.

SECTION II NEGOTIATING POINTS WITH PURCHASERS

In Peter’s and Waterman’s seminal work *In Search of Excellence*, they discuss the simultaneous loose-tight properties of business. They say that the best businesses are tight about what they expect their managers to achieve but loose about how they suggest they achieve it. Government also has ‘simultaneous loose-tight properties’, unfortunately it tends to be loose about what it wants to achieve but tight about the means. This partly explains why historically contracts with private agencies have not clearly spelled out outcomes, but have required adherence to hundreds of pages of rules and procedures. There was little room for negotiation of these rules and procedures.

When entering into risk based, performance based contracts, community based providers must re-establish their power base in the negotiation process. Bearing financial risk, often a considerable amount, *and* being responsible to achieve measurable outcomes creates a very different contracting process than under the traditional model. It *requires* negotiation around financial variables including how much financial risk, risk adjustment methods, the validity of the historical data used to establish the payment amounts, the specific population to be covered, required services, and the expected outcomes and reporting requirements. The next section of this paper addresses these negotiations.

A) Negotiation Preparation # 1 Know What You Know About What You Do

When a purchaser enters into a risk-based, performance-based contract, the data on which they base their decisions falls into four basic categories:

- ◆ Population/demographic data.
- ◆ Financial data.
- ◆ Utilization numbers of data.
- ◆ Outcome data.

It is important for the IDN negotiators to understand the purchaser’s definition of these data elements and how the information was compiled and analyzed.

Population/Demographic data describe the demographics and characteristics of individuals/ families entering the system. This data includes information such as age, ethnic background, religion, address, income level, school attendance, health history, system history, and presenting issues. This data provides the *profile of the consumer* using services.

Financial data consists of information about the historical expenditures on services for the target population. This data will be pulled from the following sources:

- ◆ Federal Reports (Amount paid for room and board (Medicaid for nursing home care, therapeutic services and health care and Title IVE for children in out-of-home care).
- ◆ State and county budgets allocated for direct services.
- ◆ Grant resources supporting the service/activity.
- ◆ Line items for administrative overhead associated with the delivering the services.

Utilization data reflects the number of services/activities used. Most states have utilization data in aggregate form; they know how many individuals were served, general kinds of services used, number of individuals in out-of-home care etc. However, in many states, inadequate data systems and fragmented programs make it difficult to track the services provided to an individual child/family. This lack of reliable data must be pointed out and can serve as a point of negotiation in the contracting process.

Examples of *aggregate* utilization data for the child welfare population might include:

- ◆ Number of children who enter the system through abuse/neglect reports
- ◆ Number of safety assessments conducted
- ◆ Number of children in out-of-home care (broken down by type of care—foster, group, residential)
- ◆ Number of children residing in out-of-state care
- ◆ Number of children referred to community-based providers and to which providers
- ◆ Number of children who have been abused while in the foster care system
- ◆ Number of children who left the system and why (adoption, aging out, moved)
- ◆ Number of children who enter into adoptive homes
- ◆ Number of Termination of Parental Rights filings and actual completion.

Examples of *child-specific* utilization data include:

- ◆ Specific number of mental health services provided to a child who entered the system with a sexual abuse allegation.
- ◆ Specific cost for respite care to the parents of a child with a significant medical issue.
- ◆ Numbers of child care slots used for a family with neglect petitions
- ◆ Cost to provide services and supports from case opening to case closure for a child who has a certain diagnosis.

RULE OF THUMB: The more specific the utilization data, the more helpful it is to the IDN in the financial planning process.

Outcome data tells state agencies whether or not any of these efforts put forth on behalf of individuals/families is producing the results desired. Some of the outcome data that state government purchasers are requiring today is being required by the federal government. When this is the case, the IDN and the purchaser, must find a way to meet the outcome reporting requirements in a way that does not place too much burden on the IDN. If the state had a tough time collecting the data in the past, the IDN cannot be expected to provide the data right out of the gate.

Examples of outcome data being required by the federal government for the child welfare system includes:

- ◆ Improved safety of children in the system (reduction in number of children harmed in foster care, reduction of number of children who re-enter the system after being returned home)
- ◆ Permanence achieved within a fixed time frame for children in the system.
- ◆ Improvements in a family's ability to nurture and parent their children (follow up research shows children are fairing well in homes where family support and family preservation services were provided).
- ◆ Increase in the number of adoptions within three months after the termination of parental rights.

Similar to utilization data, outcome data is very sketchy. Thus it is wise for the IDN to negotiate for contracts that seek intermittent improvements in outcomes. Some of the questions that should be posed during the negotiation include:

- ◆ What is the data for the past three years on the specified outcomes for the target population?
- ◆ How was this data gathered?
- ◆ How were the expected improvements in outcomes determined?
- ◆ How does the state compare to national data in the specific outcome areas?
- ◆ What are the sanctions for not reaching the desired outcomes?
- ◆ Are the improved outcomes standardized across the state? Is that realistic considering the historical picture of the outcomes? (Often inner city outcomes are much worse than rural for the child welfare population).
- ◆ What if payment isn't made in a time and manner specified?
- ◆ What if the product or service isn't provided in the method, quality, value or time provided?
- ◆ What if the present negotiations are unavailable later? Who will replace them?
- ◆ Who will prepare, review and sign agreements related to nonperformance? Never rely on your opponents people exclusively in these matters.
- ◆ Who will arbitrate differences concerning the definition of nonperformance to be applied to your agreement?

Community based agencies should use the state's planning period to prepare. If the state is considering including a certain population in the risk based contract, the IDN needs to compile its own statistics about this population including: demographic data (description of the population of users and their presenting issues); utilization trends (amount of services provided); outcomes –(how successful the providers in the network have been with this population and how this compares to the expectations of the purchaser; cost data (how the networks costs compare to risk-based financing figures that are being suggested by the purchaser).

Community-based providers need to enter into the negotiations with data that accurately represents the experiences of the members of the IDN. This means of course that members need to be prepared to provide this data. If members of the IDN do not have it the required information, they must work to compile it. Providers cannot expect to be

successful entering into a negotiation with nothing but anecdote and aggregate cost data. This preparation allows for as much equality as possible at the bargaining table.

B) Negotiation Preparation #2 Do Your Homework About Other State Models

Sometimes the best defense is a strong offense. When entering into negotiations it is wise to learn how other states that have been successful in negotiating new contracting models, conducted the negotiations. For example, when the state of Illinois entered into risk-based contracting with its community-based providers they believe that four variables contributed to the success of the negotiations:

- ◆ First, providers had access to every shred of information that could be gathered by the state about how the system had been operating. As a result there were few fears of prejudice or secret agendas.
- ◆ Second, the performance data on which the negotiations were based and which were used subsequently to monitor performance were developed by an independent third party.
- ◆ Third, the discussions were focused on the health of the system as a whole, as opposed to past attitudes or perceived performance by the public or the private system. Both sides were able to come around common goal—the improvement of the system. This proved key to progress in the negotiations.
- ◆ Fourth, both sides agreed that the onset of the contract year did not signal the end of negotiations. Everyone knew that there were bound to be problems and unforeseen issues that would arise during implementation. Points in time were set to evaluate these areas of concern.

The Massachusetts Division of Medicaid, was very successful in their shift to Medicaid AFDC Managed Care. Their success is attributed to the implementation of a negotiated model of quality assurance that involved five key steps:

- ◆ The development of contractual terms and purchasing specifications.
- ◆ The identification of improvement priorities.
- ◆ The negotiation of improvement goals.
- ◆ Efforts directed at meeting improvement goals and measurement of success.
- ◆ Collaboration to achieve mutual objectives.

Their contracts heavily emphasize quality management and continuous improvement through data collection and analysis. Each contract requires collection and submission of data, participation in quality improvement work groups, and ongoing quality studies. The Medicaid Division's priorities for improved performance were established based on negotiations on each of the following points:

- ◆ Specific community needs,
- ◆ Concerns of advocates and
- ◆ Concerns of consumers
- ◆ Perspectives of state policy initiatives.

An important aspect of their effort is that the Medicaid agency meets with providers every six months. These meetings take place at providers' sites and providers, public agency representatives and interested parties attend. The provider reports on the success they have had in achieving the outcomes and reports any struggles they are

having. The providers under the Massachusetts contract attribute the success of this model of contracting to the negotiation between the state and the providers around every aspect of the contract including the broad goals, specific performance indicators and the elements of corrective action.

As IDN's enter into negotiations, it might be wise to refer to "tried and true" negotiation models in other states.

C) Negotiation Preparation #3 --The Devil is In the Details

When entering into negotiations there are three details that the IDN must be prepared to negotiate the following:

- 1) Amount of Risk.
- 2) Risk Adjustment Methods.
- 3) Reporting requirements.

1) Amount of Risk

While risk often provokes anxiety on the side of both the provider and the payer, what risk ultimately provides is an opportunity to build administrative and service system structures that can have a positive affect on both the process of delivering services and on the quality and outcome of the services provided. This is only possible if practical and effective risk sharing arrangements are designed and implemented. Effective risk sharing will occur only if all stakeholders have incentives to take reasonable risks and mechanisms are in place to prevent unreasonable loss. In successful systems, risk is shared rather than shifted from one stakeholder to another. Again it is important for the IDN to acknowledge that the single, most important set of factors that can affect the total level of risk is the provider's ability to influence and change the historical pattern of utilization and administrative processes that have produced the current high level of costs.

A risk-bearing contract must stipulate the amount of financial risk it will expect the IDN to bear. It should also stipulate how this figure was calculated. The salient points of any discussion around risk include needs of the population, and the validity of the historical costs data.

Needs of the Population

The social service population is a high need population and the complexities of the families served are pronounced. Physical or sexual abuse, domestic violence, generations of chemical dependency and poverty, and severe neglect leave lifetime scars. Brief, short-term work, while appropriate with some will not be acceptable for all situations. Re-involvement in the system for some individuals/families can be predicted, as chronic, generational issues are rarely resolved quickly. Thus the system needs to take into account these population characteristics. Consider the following questions during the negotiation:

- ◆ What is this history of this population in utilization of services?

- ◆ Has the purchaser considered the low end, average or high end of utilization in the establishment of the rate?
- ◆ What variables were entered into their calculations?
- ◆ Are there other public funding streams such as TANF, Medicaid, education that can support the cost of services?
- ◆ Are there any regulations that if removed will make it easier and less costly to serve this population, without compromising quality?

Validity of the Historical Financial Data

It is important to use caution when basing future projections on historical service utilization patterns that may have been under funded. If funding for the system has traditionally been inadequate, basing a fee structure based these on historical figures will be lead to under service or contractor insolvency. While managing care can increase efficiency, it cannot be expected to be effective if sufficient resources are not provided to the managed care system. On the other hand, if the system has been over funded, the IDN could take savings in the form of profit, or the state general fund could benefit from reduction in expenditures in the child welfare system. It will be critical for the public agency to have sound actuarial data before moving forward, to carefully calculate real costs for services, and to define how cost savings will be redistributed within the system.

Purchasers need to be reminded of the following financing principles during the negotiation process:

- ◆ Too much risk will deter community-based providers from entering the bidding process or cause them to withdraw from managed care programs.
- ◆ Risk sharing may be unintentionally structured to create incentives for providers to underserve clients because of fiscal constraints.
- ◆ Retention of too much risk by the government fails to provide community provides with an incentive to reduce utilization.

2) Managing the Risk: Risk Adjustment Methods

There are methods that can adjust the balance of risk between the purchaser and the provider. Various types of risk adjustment methods can be established to spread risk or to buffer a community-based provider from catastrophic costs that are outside of the provider's control. Because of the complexity of the social service population, risk arrangements should be employed that afford the best opportunity for the provider to succeed, the state to achieve efficiencies and the consumer to receive quality services.

Risk Corridors

Some state purchasers are concerned that the shift to managed care may cause conscientious providers to lose significant amounts of money and drop out of the market. One method to protect against this loss is to establish a risk corridor and limit the amount of revenues that a provider can use for administration and profit, as well as limit the amount of risk the provider will bear. If the provider saves more than 10% of the total cost of the contract, the revenue is shared with the purchaser. If the provider spends over 10% of the contract, the purchaser shares the cost. This model is an

excellent model especially during the first years of the contract when the historical cost data may not be fully reliable.

Catastrophic Risk Pools

A catastrophic risk pool is used when an individual/family's care far exceeds the average of the cost of care for the target population. These pools can be established by taking a percentage of money 'off the top' of the state allocation for the contract, and placing it in a separate account. Providers may access the risk pool when the cost of serving the needs of an individual/family vary significantly from the average. This is not a method to bail out poor performing IDNs, but can serve as a protection of the community-based service network. When the purchaser is willing to entertain a risk pool, the IDN must enter into the negotiation willing to help the purchaser specifically describe the criteria for consumers who would be eligible to tap the pool. Expect that the state will (and should) exercise tight gatekeeping and utilization review, prior to allowing access to the pool.

These are some of the topics to be considered in the negotiation:

- ◆ Which individuals in the target population used an extreme portion of services? What services were used?
- ◆ What were the *characteristics* of those children and their families?
 - Presenting issues.
 - Family dynamics.
- ◆ What percentage of the total target population has these characteristics and service needs?

3) Reporting Requirements

Sometimes the gathering of data can seem like a black hole. The more you provide the more that is required. Never let the purchaser forget that data compilation is costly, regardless of the level of technology you possess. Data must be gathered, entered, reported and analyzed. Therefore, when entering into negotiations around reporting requirements it is wise to ask the purchaser to be very clear about their reasons for requiring a long list of data elements. Some of the questions that might be posed during the negotiation include:

- ◆ What does the purchaser intend to do with the data?
- ◆ Are there any external pressures (federal government, legislature, etc.) that requires the data?
- ◆ Does the purchaser have the staff to compile the data and prepare reports on the system from the data?
- ◆ Will the purchaser conduct provider profiling (comparing the outcomes, service utilization, cost of one provider to another)? On what variables?
- ◆ What is the frequency of the reporting?
- ◆ What is the manner of the reporting? Electronic? Manual?
- ◆ Will the IDN be required to purchase any software in order to fulfill this reporting requirements?
 - If so what type and cost?
 - Will the new software be compatible with the IDNs own system?
 - Can the systems talk to each other?

- Will staff have to learn new software?
- ◆ What is the expected time of data entry per month? Cost for this process?

Final Thoughts

Enter into contract negotiations with the expectation that they are really never fully done and stress that during the negotiations. A contract can be changed or modified with the agreement of both parties. We are in a learning cycle around risk-based, performance-based contracting. Therefore the best-case scenario is to find ways to secure a commitment by the purchaser to use the initial stages of contracting as a learning process for the entire system. Ask for points in time when the assumptions made during the negotiations and contracting process can be evaluated. Were they accurate assumptions? Did they hold true under the test of system operations? For example, was the risk corridor too much? Too little? Did more clients have access to the catastrophic risk pool than anticipated? What does this say about the financing?

The system of supports provided by the not-for-profit providers in this country is the safety net for our country's most vulnerable populations. Not-for-profit providers contribute significant resources in the way of in-kind donations, Untied Way dollars and fund development to support the system of care. The not-for-profit provider is valuable to the strength and solvency of the system. As such, it makes little sense for a purchaser to glibly enter into contracts that have no hope of working-thus placing the not-for-profit sector in jeopardy. The negotiations are an excellent point in time to remind the purchasers of this reality.