

MANAGED LONG
TERM CARE
BEST PRACTICES
GUIDE FOR SENIOR
SERVICE PROVIDERS



New York City Department for the
Aging



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Commissioner

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October 2012

Dear Long Term Care and Senior Service Providers:

The Department for the Aging (DFTA) is pleased to publish its “Managed Long Term Care Best Practices Guide for Senior Service Providers.” The Guide presents information to aging services providers and Managed Long Term Care (MLTC) organizations that are looking to enhance their existing partnerships or forge new ones. We believe that these partnerships can benefit both systems, which have not always worked closely together in the past, while strengthening services for older New Yorkers in need.

It is an auspicious time for this conversation: the health care system is undergoing tremendous change at both the federal and state levels, and with those changes come new opportunities. One major difference is New York State’s enrollment of many older New Yorkers over the coming months into MLTCs for their receipt of Medicaid funded long-term care services. Mandated enrollees will include older New Yorkers eligible for Medicaid and Medicare services who are also eligible for at least 120 days of long term care services annually and who otherwise can safely remain in the community. At the same time, the number of older New Yorkers is increasing rapidly, and we must find ways to coordinate service delivery within and between the health care and senior services networks to maximize the impact of services that we can provide to them.

In that spirit, we are sharing this guide, which includes direction on potential partnerships involving MLTCs and Social Adult Day Care (SADC) programs, as well as MLTCs with home delivered meal providers and senior centers.

The document benefits from significant contributions by our partners at the Community Resource Exchange (CRE) and downstate representatives from the New York Social Adult Day Services Association (NYSADSA). We thank NYSADSA for fashioning the sections that cover the process of establishing linkages from intake through to billing. We also want to extend our appreciation to CRE for preparing a booklet that will help MLTCs and aging services providers negotiate reimbursement strategies for their partnerships. This has been incorporated wholesale into the Guide.

We strongly believe that the establishment of linkages between MLTCs and aging services providers is one of the most promising means to tap into existing resources in ways that create synergies of great benefit to older New Yorkers while enabling both MLTCs and aging services providers to better meet their mandates. We are eager to continue this dialogue and work together in ways that will benefit clients and enrich services that MLTCs offer them.

Sincerely,

A handwritten signature in black ink, appearing to read "Lilliam Barrios-Paoli". The signature is fluid and cursive, with a large initial "L" and "P".

Lilliam Barrios-Paoli
Commissioner

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Section I – DFTA Best Practices Guide

I. Intake & Assessment

Intake begins when an individual is referred to a Managed Long Term Care Company (MLTC). As a first step in processing that referral, an MLTC typically receives basic demographic and caregiver information. The MLTC then contacts the referred party and conducts an assessment to determine that party's eligibility for enrollment and interest in the MLTC. In other cases, an enrollment facilitation entity, Maximus, makes a referral on the party's behalf to an MLTC if a person is mandated to enroll in an MLTC plan and does not voluntarily select one.

An MLTC care manager next will open a case, as well as assess various domains including the individual's medical, psychosocial, and functional statuses, the person's cognitive ability, mental health and living arrangements. MLTCs currently conduct their assessments using the State Department of Health's (NYSDOH) Semi-Annual Assessment of Members (SAAM) tool. It is expected that a new Universal Assessment Tool will replace the SAAM during 2013. Once the assessment is conducted, the MLTC then implements an individualized care plan for its new member. As part of the care plan, a nurse conducts a home visit. An MLTC's social worker may also conduct an assessment. Together, after assessment, the nurse and social worker finalize the care plan.

II. Referrals

Based on member needs and the individualized care plan, the member will be referred to appropriate services in the MLTC's network. The care manager is responsible for coordinating and adjusting individuals' care with network members to ensure service quality at the member's home and during transitional periods such as hospitalizations and short-term rehabilitation. Communication is critical between the MLTC and its provider network to ensure that services are adjusted to reflect a member's changing health circumstances. For instance, an MLTC and Social Adult Day Care (SADC) program must have ongoing communication regarding a member's functional status and schedule of visits.

A strong relationship between an MLTC and a provider is essential for successful referrals. An initial outreach call is usually made to the provider to explore the case in detail. This call helps further determine eligibility, appropriateness and overall fit between the needs of the consumer, the MLTC, and the provider. For HDML and senior center referrals, this initial call is often all that is needed to finalize the referral. Because of the more complex nature of SADC referrals, a series of calls, e-mails and faxes are sometimes required in order to better clarify needs of the consumer and caregiver, and to compare this with the capabilities of the respective parties. Below, please find specific examples of coordination between an MLTC and its network:

Social Adult Day Care

If an MLTC care manager or social worker identifies a need for SADC services, the individual will refer the member to an SADC in the MLTC provider network. The care manager or social worker will contact the SADC program directly to make the referral. The MLTC referrer,

caregiver and member provide basic demographic, medical, psychosocial and functional information to the SADC.

Thereafter, the SADC contacts the MLTC member to schedule an assessment. If the member or the member's caregiver is interested -- and, following an SADC's assessment, deemed eligible for SADC services -- the SADC will work with the MLTC care manager to set up an attendance schedule and transportation. The member enrolls in the SADC (which includes the completion of Health Insurance Portability and Accountability Act (HIPAA) forms). The SADC then completes its own care plan for the member within 30 days of enrollment.

Please note: further information specific to SADC referrals and SADC case studies is provided in Addendum I. Although this Addendum is aimed at SADC providers, senior center and HDML providers may find it helpful to review the Addendum as well.

Home Delivered Meals

If an MLTC's care manager identifies a need for home delivered meals, the MLTC refers the member to a home delivered meal provider (HDML) in the MLTC's network. The care manager contacts the HDML provider and sends a written referral, including the member's basic demographic, medication and emergency contact information. The HDML provider conducts a site visit to the member's residence to complete an assessment. During the HDML assessment visit, dietary requirements are established and emergency contact information is verified. HDML staff members conduct home visits every six months to ensure that member information is current.

Senior Center

If an MLTC care manager identifies a need for senior center services (e.g., health and wellness activities), the care manager will refer the member to a senior center in the MLTC provider network. The care manager will contact the senior center directly to make the referral. The MLTC referrer and member will provide basic demographic information to the senior center.

Referral Best Practices

Members expect to have a voice concerning where they receive their care within an MLTC's provider network. It is therefore best to inform the consumer or caregiver of recommended services in advance of a formal referral.

MLTC network providers should not feel obligated to furnish services for a member if a provider does not feel its service is appropriately matched to a client's needs.

To ensure MLTC case workers and administrators find the best fit between their members' needs and their networks of providers, MLTCs should be encouraged to keep a detailed written description of each provider in their networks. These rosters should include the following: contact information; location and service geography of the provider; a listing of the services provided; special populations served; special nutrition services provided (if relevant); and unique characteristics of the program or services offered.

III. Tracking & Reporting

Each MLTC contract should outline clearly for prospective network providers how data are to be tracked and reported. The prospective providers, in turn, should make sure to inquire about such matters during any contract negotiation with an MLTC, thereby making sure that their record keeping billing systems are compatible with an MLTC's requirements. This is critical because data collection and maintenance will play a significant role when providers bill MLTCs for services provided.

For senior centers and SADCs, it is important for providers to keep daily attendance rosters to document participants' attendance. HDML providers should keep lists of daily meal recipients. These rosters should clearly identify which participants are MLTC members and state which MLTC has authorized services. Documenting in this way makes it easier when it is time to bill the MLTC for services. In addition to identifying the authorizing MLTC, the roster should reflect whether the MLTC paying for the client uses a flat- versus hourly-rate system. As well, each activity provided during the day should be reflected on the attendance sheet and noted on the participant chart, e.g., a health class, bathing, meal, transportation, etc. Providers bill the MLTC by the terms set forth in the contract, which should delineate each authorized service.

Providers are responsible for making sure their records are up-to-date for billing purposes. MLTCs employ differing billing formats: some will provide forms while others will accept a provider-generated invoice. The formats for reporting and billing should be specifically stated in the contract between an MLTC and a network provider and also delineate the MLTC's payment cycle. Providers are responsible for contacting the MLTC to inform the care manager of any change in care that a member would require. In addition, providers are responsible for monitoring authorizations to make sure the participant remains eligible for services because most MLTCs will authorize services for an established period of time, e.g., six months.

For SADCs, by following the SOFA standards and utilizing SOFA's intake forms, a care plan for each participant can be created and can be used to satisfy the MLTC requirement for level of care and quality of service. NOTE: As of October 1, 2012, DOH requires that MLTCs contract only with the SADC programs that adhere to the SOFA standards. Depending on the MLTC contract, providers may be required to provide written documentation or provide information to the participant's case manager over the phone regarding services, days of attendance, and functional status.

Tracking and Reporting Best Practice

It is strongly recommended that the provider assign or hire a staff person to be in charge of monitoring MLTC contracts to ensure continuance of eligibility and services. The designated staff will be responsible for billing and should have prior experience in billing/accounting. In addition, this person requires communication skills to follow up with case managers as needed. Follow-up is a key component of the billing process and must often be initiated by the provider. Tracking and data collection are critical to the billing process; therefore, specific documentation is required, as described above.

Billing is critical to the financial stability of the program, and the bills must be accurate in order to prevent delays with payment. Each bill must clearly and accurately reflect the day and date for each service, with the accompanying cost for the service. Because each MLTC contract may be different, billing is a labor-intensive task and often takes hours of work. Therefore, it is important to make sure that the designated staff person has the training, time and space needed to accurately perform this multi-faceted job. Providers must remember that each MLTC contract may have different reimbursement cycles, and cash flow is an issue that providers must take into consideration.

The Community Resource Exchange (CRE) has prepared a booklet entitled *Non-Profits: Guidelines When Considering Agreements with Managed Long-Term Care Companies*, which provides extensive information on how to go about determining fees to charge for the provision of aging services and how to work with the MLTC on such issues. This booklet is available on the Department for the Aging (DFTA) website at www.nyc.gov/aging.

IV. Marketing Tips

These Guidelines offer guidance to those aging services providers that are considering the development of service agreements with Managed Long-Term Care Plans (MLTCs). Please note that DFTA does not require aging services providers to adhere to these Guidelines as they are not regulations. Instead, DFTA is disseminating them to providers and other interested programs that may want to use them as a reference while developing relationships with MLTCs.

Definitions:

- a) “Providers” shall mean aging services providers (e.g., senior centers; home-delivered meal providers).
- b) “Marketing” shall mean all forms of communication, written or oral, used to inform aging services program participants about different MLTC plans, including communication that encourages or induces participants to enroll in an MLTC.

Appropriateness of Marketing Materials:

- a) Many Social Adult Day Care (SADC) attendees experience cognitive challenges; direct marketing activities to SADC participants with cognitive challenges are not advised.
- b) Only marketing materials approved by NYSDOH for MLTCs may be used and distributed by such plans. NYSDOH must approve any marketing materials prior to their release. The provider may request proof of that approval from the MLTC plan. If a provider is uncertain that materials meet such parameters, the provider should contact the MLTC.

Permitted/Impermissible Marketing Activities:

- a) Providers at their service sites may wish to limit or prohibit MLTC marketing in their facilities and/or choose not to distribute marketing materials. In such instances, if an individual seeks information concerning MLTC plans, the provider may refer that person to NY Medicaid Choices (Maximus).
- b) Providers should not provide mailing lists of their participants to MLTCs.
- c) MLTCs should not collect personal information at providers' service sites, including names, addresses, social security numbers or identifiable medical information. To that end, MLTCs should share with the provider copies of any forms that they intend to distribute prior to the presentations.
- d) All MLTC marketing activities should be conducted in an orderly, non-disruptive manner and should not interfere with the privacy of potential participants or the general community.

Enrollment:

- a) MLTCs should not offer material or financial gain to Medicaid beneficiaries as an inducement to enroll. Specifically, MLTCs should only: 1) make reference in marketing materials and activities to benefits/services offered under the program; and 2) offer only minimal gifts, with a fair market value of no more than \$5.00, with such gifts being offered regardless of the beneficiary's intent to enroll.
- b) An MLTC should not pay any individual or program a commission, bonus, or similar compensation as an incentive to increase the numbers of enrollees in that MLTC.
- c) Individuals who qualify for receipt of Medicaid funded long-term care services may never be told that they have to join an MLTC plan until they receive official notice to that effect from the State or its designee. Even then, the individual may elect not to choose a plan, but after 60 days, this will result in the recipient's automatic assignment to such a plan as a condition for receipt of long-term care services.

Addendum I: Social Adult Day Case Studies

I. Referral Process Detail

First, both the MLTC and/or the SADC program should have a signed HIPAA form in order to freely engage in cross communication and to provide written clinical documentation. Matching needs with the best plan or day center provider is a process of discovery, and prior experience between the parties working together to meet consumer needs often facilitates the development of a clear understanding of the strengths, capabilities and limitations of each party as they relate to the needs of each member. Upon deciding that the consumer is appropriate to make a formal referral, the referring party then speaks in detail with the consumer and/or caregiver to obtain consent to move forward with the referral process. Often times this consent is given to the referring party prior to the MLTC or SADC provider making this decision, as prior discussions with the consumer or caregiver have identified goals, wishes, and preferential choices.

If the referring party is the MLTC and a decision to make a formal referral has been agreed upon verbally, the parties can then move forward accordingly to solidify this commitment. The MLTC may give a verbal referral, but often a written referral form provided by the SADC provider is faxed or e-mailed to the SADC provider. Additional bio-psycho-social information from the MLTC may be requested by the SADC provider at this time.

If the referring party is the SADC provider and a decision to make the formal referral has been agreed upon verbally, the parties can move forward to solidify this commitment. Most often the SADC provider utilizes the MLTC referral form, and this form is faxed or e-mailed to the plan for immediate follow-up with the consumer and/or caregiver. If the MLTC requests background bio-psycho-social clinical information, the SADC provider will provide the information at this time. Often times the consumer will be or has been enrolled into the SADC center prior to formal enrollment into the MLTC.

If the referring party is the MLTC, the SADC provider will call the consumer and/or caregiver to explain the details of the services provided and to set up a day to visit the center and learn more about the program at the day center. The SADC provider will complete their own bio-psycho-social needs assessment, enrollment forms, and other agreements at this visit with the consumer and/or caregiver or both. Upon completion of this visit, the SADC provider will then call the MLTC and inform the plan that an assessment has been completed and request written authorization to begin care at the center. The MLTC will then fax, e-mail or mail a written care authorization to the SADC provider to keep for their records.

It is critically important that a full bio-psycho-social assessment be completed by the MLTC and/or SADC provider in advance of making the outreach call to explore the appropriateness of the referral. It is through the assessment process that an adequate fit between the parties can be determined, and without such detailed information an incorrect referral can be made without fully understanding the strengths and limitations of the parties. A phone call with a social worker at the SADC program, or program director and the social worker, nurse or case

manager or other designated staff member at the MLTC, is best practice when initially determining the appropriateness of a referral to either party.

A six-month authorization for services, along with the number of days authorized per week, is important for the SADC program to develop a care plan and ensure a standard weekly schedule for the consumer. It is best practice for either the MLTC and/or the SADC program to educate and inform each caregiver on the full range of support services provided to the caregiver at the center, as well as any other supportive services offered in the community. It is recommended that the SADC program obtain a full list of medications currently being prescribed to the day center member as well as a listing of the name of the primary care physician, address and phone number. The day center should request from the consumer and/or caregiver all background psycho-social and medical information upon visiting the center for the initial assessment.

II. SADC Case Studies

a) Intake & Assessment Case Study

The MLTC care manager received a new enrollment request for Ms. L., who is 82 years old, has diagnoses of diabetes, hypertension and depression, is taking seven medications, and is living at home with her granddaughter. The MLTC care manager makes a home visit to open the case and begin care management of the member. The MLTC care manager evaluates the member's medical, mental health, nutrition, cognitive and ADL/ IADL status as well as living situation and formal/ informal support systems. The care manager implements an individualized care plan and authorizes services based on the member's needs.

Ms. L. is not safe at home alone, and her granddaughter works full-time during the day. No other support systems are available. The MLTC suggested social adult day care, but the granddaughter and member are not interested. Ms. L. is depressed, becomes agitated at times, and does not want to leave the home. The MLTC has authorized five days x 10 hours HHA services Monday through Friday, and two days x four hours for the weekend.

The MLTC social worker makes a home visit to assess the member. The social worker suggests that Ms. L. will benefit from the socialization and stimulation provided at the SADC. The MLTC social worker discusses benefits with the family and encourages them to try a visit to the SADC. The granddaughter and member are in agreement. The social worker communicates with the MLTC care manager. The MLTC social worker identifies an SADC near the member's home in the MLTC provider network. The social worker contacts the SADC to make the referral. The MLTC care manager authorizes transportation for the SADC assessment visit.

The SADC contacts the granddaughter to discuss needs and arrange an assessment visit. The granddaughter, HHA and member visit the center. (The HHA attends the assessment visit only. Once the member is enrolled in SADC, the HHA does not attend with the member.) The SADC conducts an assessment of medical, psychosocial, functional and cognitive status, including information from the MLTC and caregiver. As part of SADC assessment visit, Ms.

L attends a music therapy session, is fully engaged and expresses interest in attending. The SADC determines that Ms. L is eligible for SADC and discusses attending twice a week with the granddaughter. The SADC and granddaughter are in communication with the MLTC care manager. The care manager authorizes SADC two days a week, and reduces HHA hours on those days that Ms. L. is scheduled to attend SADC. After two months of attending the SADC, the granddaughter contacts the MLTC care manager and social worker to discuss increasing days at SADC. The granddaughter reports to the care manager that the member is more alert and verbal, and her depression is reduced. The care manager authorizes SADC five days a week and changes HHA hours to provide three hours of afternoon HHA after SADC. The MLTC and SADC have ongoing contact regarding the member's participation in SADC.

b) Referral Case Study

A nurse case manager from an MLTC meets with the clinical team about an assessment made on a new case enrolled into the plan. It has been determined through a mini-mental exam in the home setting that the member has dementia, is wheelchair bound, and is experiencing depressive symptoms. After careful review of the formal/informal supports, nutrition needs, health, ADLs/IADLs, psycho-social condition, and personal history, it is determined that a referral to a SADC center will be made. The team identifies that there is a program specializing in dementia care in the borough where the member resides and is contracted with the plan to provide services.

It is further determined that the center offers transportation in the zip code where the consumer lives. The case is assigned to a social worker at the plan with a directive to call the caregiver of record and determine the interest in having their loved one attend this SADC center, and upon approval to call this center, to determine if there are openings at the center for new members, and to explore if the case is generally appropriate for a formal referral. The social worker calls the contracted center, and the program director of the day center reviews the details of the case with the social worker. It is determined that the case appears to meet the criteria for referral and that the center can accommodate the member five days a week. The day center agrees to accept a written referral, and the social worker of the plan then faxes over a formal referral utilizing the respective day center's referral form. The day center staff member calls the caregiver listed on the referral form, discusses the general needs of the family, and schedules a site visit with the caregiver. The caregiver is asked to bring a list of all current medications that their loved one is receiving, all background clinical information on the loved one's diagnosis of dementia and any other pertinent health and other information that would be important to determine how best to support the care needs of their loved one.

Upon visiting the center, the program director completes a full bio-psycho-social assessment and determines that the member is eligible and appropriate to attend the center. The center makes referrals to other health and community services such as the local Alzheimer's Association chapter, and to a diagnostic medical center or neurologist to obtain a full differential diagnosis to identify the type of dementia the person is experiencing. A trial day is scheduled for the loved one and a general plan of care is developed. The staff member of the day center calls the MLTC social worker on the phone and states that a full assessment has

been completed by the day center and that authorization for five days of SADC services per week is requested. The social worker of the MLTC confirms that the care is authorized and faxes the SADC center an authorization for six months of care for five days a week of attendance, along with transportation services.

c) Tracking and Reporting Case Study I

The Director of the SADC received a call from a caregiver stating that her husband had been diagnosed with dementia, and she was having difficulty keeping him at home. He wanted to walk around the neighborhood and she was afraid he would get lost, but if she tried to keep him in the house, he became belligerent and she was afraid he would hurt her. She wanted him enrolled in a SADC program during the day so she could take a break from caregiving. He was 82 years old and she was 80.

A program application was mailed to the caregiver and an intake interview scheduled. Her son accompanied her and his father to the interview. The wife stated that they were running out of money fast and it was recommended that she schedule a consult with an elder care attorney. She was given a list of attorneys in the area. At the same time, she was given a subsidy application to show to the attorney in the hopes that she would qualify for a reduced cost for the SADC until the Medicaid process was completed.

Her husband entered the program six days per week while the family worked with the elder care attorney to complete and submit a Medicaid application. The process took a number of months. At the same time, her husband was becoming more and more belligerent, so she was referred to the Geriatric Psych Division of Hillside Hospital, NS/LIJ, so that her husband could be evaluated for medication. This was done and a medication regime was recommended. He continued to attend the SADC program.

Once the Medicaid was approved, the MLTC representative was called and the case was discussed and a referral was made. She called the caregiver and the assessment phase began. He was authorized by the MLTC to attend SADC for six days per week, including lunch and transportation for six months. After a few months it was evident to the program staff that his hygiene had deteriorated. A call was made to his wife but it was clear that she was unable to thoroughly assist him at home. A call was made to the MLTC rep to discuss this concern. The MLTC then authorized the center to bathe and shave the participant two days per week, thus relieving the burden from the caregiver.

This is a good example of how the SADC and the MLTC worked together for the sake of the caregiver and the care recipient.

Each day that the participant attends, he is identified as an MLTC member on the attendance sheet. His time of drop-off and pick-up are clearly marked on the attendance sheet. The transportation provider is listed and the number of trips clearly indicated, i.e. one-way versus round trip. On the days he receives a bath, this is also indicated on the attendance sheet. Since the MLTC contract was negotiated as an hourly rate along with a list of ancillary services, the program hours are calculated each day and entered into the computer on a data base along

with any ancillary services he received. At the end of each month, MLTC is billed for the program hours, number of transportation trips and number of baths at the rate negotiated in the contract.

d) Tracking and Reporting Case Study II

A participant was referred to the SADC by an MLTC. He was living with his brother and sister-in-law, was diagnosed with dementia and needed to be in a program six days per week with round-trip transportation. A program application was sent to the family, an intake interview was scheduled, and then the MLTC rep called to negotiate the number of days he was to be authorized for. He was authorized for six days per week.

After a number of months, it was obvious to the program staff that his appetite had changed and because he was not eating as much as before, there was a noticeable change in his weight. The family was called who confirmed the same behavior/changes at home. The MLTC rep was then called to discuss the case. A nurse evaluator was sent to the home to assess the situation. His days were reduced at the SADC to three days per week and an aide was placed in the home. All parties involved in his care encouraged the family to have him evaluated by a physician. This was done but there were no significant findings. After another few months, it was evident to the program staff and the transportation provider that he had become too frail to walk up the steps of the bus, and seemed to have become weaker and weaker. The MLTC rep was consulted once again to intervene with the family. The family wanted him to continue to attend the SADC, but it was evident that this was not possible. The MLTC placed a full-time aide in the home and the authorization for SADC services was stopped. The MLTC also provided home delivered meals to the family for him. He had been on a vegan diet and the family was adamant about this continuing. Through discussions with the HDML, the SADC and the MLTC provider, a diet was agreed upon by the family.

While he was in the program, his attendance was marked on an attendance sheet, the MLTC clearly identified, along with his dietary and transportation needs. The billing was completed according to the data collected.

In both cases, it is clear that case management plays a big role in the successful relationship between the provider and the MLTC. SADC does not/cannot bill for case management but this service along with timely communication play a major role in providing comprehensive, quality services for the care recipient and the caregiver and serves to solidify the relationship between the provider and the MLTC. In order for the service delivery to be as seamless as possible, the provider and MLTC must develop a strong relationship based on mutual respect and understanding of parameters. Communication, explicit data collection and documentation, and teamwork are the keys to successful service delivery, tracking, reporting, and billing.

Section II – Community Resource Exchange Guidelines

Non-Profits: Guidelines When Considering Agreements with Managed Long-Term Care Companies

Part 1: Preparing Your Financial Systems for MLTC Contracts

- 1) Overview: It is important that your organization know the differences between a cost reimbursement contract and a unit-based payment contract resulting from agreements with Managed Long Term Care (MLTC) programs. Unit based contracting has a significant risk/reward factor in that an organization has the potential to either generate a surplus, or amass a significant deficit.

These unit-based contracts have different requirements, and will vary depending upon whether they are with government or private funding sources. Therefore, they require a different approach. To illustrate the differences, please see the table below.

	Cost reimbursement contracts	Government-funded Unit based contract	Private Unit based payment contract
Basis of payment	Reimbursement of approved expenses made to complete the contract	Delivery of units of services at an agreed upon rate.	Delivery of units of services at an agreed upon rate.
Time period	Expenses must be incurred during the contract period.	Units of services must be delivered during the contract period.	Units of services must be delivered during the contract period.
Budgeting	Organization must follow the approved budget, and may need advance approval to modify the line items in the budget.	A budget is a planning tool for the organization but requires programmatic and budget approval for modification of restricted line items.	A budget is a planning tool. It is unlikely that programmatic and budget approval for modification of line items will be required.
Under-performing in the deliverables	Unless the contract has a clause that involves reductions of the contract amount due to under- performance, the organization is still reimbursed for reimbursable expenses in the contract.	Payments are directly impacted by decreased units of service.	Payments are directly impacted by decreased units of service.

	Cost reimbursement contracts	Government-funded Unit based contract	Private Unit based payment contract
Cash flow	In most cases, the funding sources will provide some cash flow assistance in the form of a contract advance that is recouped on the back end of the contract.	In most cases, the funding sources will provide some cash flow assistance in the form of a contract advance that is recouped on the back end of the contract.	Contract advances are unlikely.
Documentation	Must maintain documentation for both deliverables and for expenses. Both are subject to future audits.	Most critical documentation items are eligibility and units of service. Expenses, units of service, and eligibility (if applicable) are subject to future audits.	Most critical documentation items are eligibility and units of service. Eligibility and units of service are subject to future audits.
Realizing cost savings	Reduces the amount that will be reimbursed.	Increases surplus for the organization.	Increases surplus for the organization.
Risk/ Reward	Financially the best an organization can do is break even.	Organizations have the potential to generate a surplus if they are efficient. Organizations also have the potential to have significant deficits if they do not control costs and closely monitor the expenses incurred vs. revenue generated. .	Organizations have the potential to generate a surplus if they are efficient. Organizations also have the potential to have significant deficits if they do not control costs and monitor the expenses incurred vs. revenue generated..

Following is a summary of a tiered approach to shared cost allocations that aging services providers may want to consider in arranging contracts with MLTCs, and potentially with other types of providers as well. This tiered approach is based upon the amount of income the new program generates in comparison to the Department for the Aging (“DFTA”) funding that is in place. This approach is laid out using DFTA contracts to illustrate sharing of cost allocations. There are three suggested tiers:

- (1) Income generated by the new program represents less than 10% of DFTA funding, e.g., the DFTA contract is \$500,000 annually; new revenue is less than \$50,000.

Only additional direct costs such as meals served to non-DFTA eligible participants should be charged to the new program. Staff, rent, utilities, etc., will continue to be charged to DFTA.

- (2) Income involved represents 10% to 30% of DFTA funding, e.g., DFTA contract is \$500,000 annually; new revenue is more than \$50,000 but less than \$150,000.

As before, all direct costs should be charged to the new program.

In addition, staffing costs should be allocated by an approved methodology. Some examples of acceptable methodologies are: timesheet tracking, allocation by number of participants, or allocation by participant hours.

Rent, utilities, etc., will continue to be charged to DFTA unless these costs are increased due to additional staff.

- (3) Income involved represents more than 30% of DFTA funding, e.g., DFTA contract is \$500,000 annually; new revenue is more than \$150,000.

All direct and shared costs should be charged to the new program. Shared costs should be allocated by an approved methodology.

2) Developing a detailed shared cost allocation methodology:

- a) When DFTA or any government agency has a cost reimbursement contract with a provider, it is important that their funds are being utilized for the purposes for which they were given. Therefore, when shared costs are involved, the provider must be able to document the methodology used for charging shared costs to DFTA. It is prudent for the organization to get advance approval of that methodology by funders. The allocation methodology that will be used should be in writing and presented to the funding source for the approval.
- b) Different circumstances and types of expenses may require different allocation methodologies. For example, an organization that has two distinct programs that utilize two separate areas of the same rental space, often will allocate space related costs by square foot. However, another organization that has two distinct programs that utilize the same space at different times, will likely allocate space costs by time the space is utilized in a typical week or month.

It is important that each organization consider what constitutes a reasonable and justifiable methodology for the different types of expenses it has, keeping in mind its specific circumstances. In the next section, we will give some examples of possible methodologies.

It should be noted that one methodology that is generally unacceptable to funders is: “these are the amounts we budgeted”. Allocation methodologies must be based on usage, not budgets.

c) Below are some sample methodologies:

- i. Allocation of staffing costs: Time sheets are critical in tracking the level of effort for an employee for a given program and should serve as the basis for a salary charge to be allowable to a specific program. Employees should prepare time sheets after the fact, and these timesheet should specify % effort on each program.
- ii. Allocation based on full-time equivalent (“FTEs”): The cost of office supplies, copiers, telephones, service contracts, etc., is often based upon the number of FTEs working for each program. For example: There are 3 FTEs employed in Program A, and 7 FTEs employed in Program B. The cost of shared supplies where both programs operate is \$1,000. Program A pays 30% or \$300 ($3/10 \times 1,000$) and Program B pays 70% or \$700 ($7/10 \times 10,000$).
- iii. Allocation based on square footage: Space-related cost (rent, utilities, maintenance, etc.) allocations are often based upon the usage by each program. For example: There are two programs in the same location. Program A occupies 65% of the space, and Program B occupies 35%. The cost of monthly rent where both programs operate is \$10,000. Program A should pay \$6,500 ($65\% \times \$10,000$), and Program B should pay \$3,500 ($35\% \times 10,000$).
- iv. Allocation based on Revenue: Often agency-wide expenses (liability insurance, audits, legal, etc.) are allocated based upon the revenue of each program. For example: Program A has income of \$250,000 and Program B has revenue of \$750,000. The cost of liability insurance annually is \$10,000. Program A should pay 25% or \$2,500 ($250,000/1,000,000 \times 10,000$), and Program B should pay 75% or \$7,500 ($750,000/1,000,000 \times 10,000$).
- v. Indirect costs such as senior management, accounting, etc., are often grouped together in an indirect rate and then charge based as a percentage of revenue. Often funding sources will establish policies as to what indirect rate is acceptable, and what is included in the indirect rate.

As stated earlier, it is important that each organization consider what constitutes a reasonable and justifiable methodology for the different types of expenses it has, keeping in mind its specific circumstances. It should document that methodology and then consistently apply that methodology to expenses.

- 3) It is required that organizations setup their books so that DFTA income and expenses are segregated from other funding sources, including those from unit-based funding. All accounting software packages have the capacity to do this. If your organization has primarily been funded by a single source, it may require some changes in your chart of accounts. (Note: DFTA may have some limited technical assistance available if your organization should need assistance in revising your accounting structure.) Some of the key elements in this are:
 - a) Establishing separate cost codes for each funding source/ program. Different accounting packages use different names – classes, cost centers, departments, etc. Regardless of the name, an organization should organize their books with different cost codes for each of their funding sources, since this is for whom they primarily have to provide financial reports. This will allow the allocation of income and expenses to each funding source.
 - b) Shared expenses. Once the allocation methodologies are determined, each shared expense should be split to the different cost codes. Most accounting packages have ways to set up recurring allocation methodologies to minimize the work involved to do this. Typically, these allocations can be set up based upon either percentages or amounts.
 - c) Allocation methodologies should be revisited periodically (quarterly) and re-calculated for the next period. Documentation of the calculations made for each period should be kept along with supporting materials. This is will minimize issues if allocations are challenged in future audits.
- 4) Other Key Documentation: It will be critical for an organization that has multiple funding sources such as a managed care funded program to maintain required documentation for all of its programs/clients. In addition to the financial records covered previously, organizations should maintain clear documentation of the following:
 - a) Client Eligibility: It is unlikely that a client will be eligible to receive services from both DFTA and the managed care funded program at the same time. Therefore, the organization must distinguish and document who is a DFTA client and who is a managed care client. Prior to be accepted in the program, the staff must document the program for which the client is eligible. When monthly billing is prepared, there needs to be a roster indicating the program that each client is a part of. If there are instances in which the client will receive both DFTA-funded as well as MLTC services, it will be necessary to develop mechanisms and protocols to distinguish the source of the funding for the specific services.

- b) Tracking units of service: Clear systems that are approved by the funding sources must be in place to track and document units of services, especially since these are the basis of payment. Periodic review by supervisors of that documentation is critical to ensure that records are accurate and up to date.

- c) Ongoing eligibility: In MLTC programs, clients' eligibility may end or be terminated. Organizations need to institute systems that periodically check continued eligibility or they may discover after that fact that they have been provided services that will not be reimbursed.

Part II: Negotiating Contracts with MLTCs

- 1) Following the guidelines above (i.e., having a shared cost allocation methodology) will help position you to negotiate a favorable unit-based contract with MLTCs. Most directly, the strength of your accounting and financial management systems will help you negotiate an optimal rate. Take the following steps to accurately price out your services and develop your proposed rate:
 - a) *Get a sense of what the market may bear.* If your agency is new to negotiating contracts with MLTCs, it is best to have at least some sense of what range of rates the market will support. Colleagues from other organizations that have negotiated (or are in the process of negotiating) similar contracts are an excellent source of current information. Associations (such as the Home Care Association of New York and New York State Adult Day Services Association) may also be good sources of information. The important thing here is to establish a baseline.
 - b) *Understand your organization's true cost of providing these services.* Include the following into your analysis:
 - i. *Direct costs.* These are expenses that directly relate to the delivery of the services. On the personnel side, remember to include those staff who have a supervisory role in the program as well as front-line program staff. In terms of other than personnel service (OTPS) lines, ensure that all direct, non-personnel costs (such as food and program supplies) are factored into your analysis.
 - ii. *Shared costs.* As mentioned above, it is important to capture expenses that are shared among multiple programs and organizational functions. Rent, utilities, office equipment usage, liability insurance are all critical to the delivery of your program and thus are legitimate expenses to factor into your calculations. Thoughtful use of the above allocation methodologies (FTEs, square footage, etc.) will help you allocate an accurate, defensible amount to your program. Ensure, however, that you use the allocation methodology that best fits your program model. If, for example, your program uses a relatively small percentage of the program space but a comparatively larger percentage of personnel, the use of square footage as an allocation methodology may will under represent the program's true costs. In this case, you should consider using percentage of FTEs as the allocation methodology.
 - iii. On the personnel side, make sure you capture any administrative staff that has a direct role in program operations, such as an administrative assistant who arranges

transportation for clients. Using timesheets, as mentioned above, will help you identify all staff involved in the program's operations.

- iv. *Administrative costs.* You want to understand the program's true share of administrative overhead (which is typically expressed as a rate) and not rely on the allowable rate from your government contracts or foundation grants. Lump together all administrative costs that support the operation of the overall organization, including financial management, HR management, and executive management. If you are costing out an individual program, that program should be "charged" a percentage of indirect costs based on the program's expenses relative to the organization's overall budget.

The sum total of all of these costs should give you a close approximation of your program's true costs.

- c) Here are a few other items you should consider when calculating your rate:
 - i. *Business model.* While a daily rate is the industry standard, it may not best fit the operating model of your program. Consider, for example, using an hourly rate if clients have the option to come for shorter periods of time, as in the case of social adult day programs. You may also consider negotiating a separate price for ancillary and/or optional services (like bathing).
 - ii. *Start-up costs.* What additional expenses might you incur, if any, to begin providing services to the MLTC referrals?
 - iii. *Factoring in the cost of ramping up.* It is likely that the number of referrals or units of service will not meet the number in your business model for an extended period of time. During that ramp up period, often the expenses will exceed the revenue until the break-even point is reached. This should be anticipated in advance, and a ramping up strategy and budget should be developed.
 - iv. *Increased capacity needs.* Your current cost model is likely tied to your current census. Understand at what point an increased census will trigger changes to your expense model. Examples here are staffing, food, and space. Any anticipated increases to your expenses should be factored into your cost analysis.
 - v. *The value of a margin.* Over and above your true costs, consider building in a margin. This will help address any unanticipated costs that occur throughout the contract period.

- vi. *Compare your true-cost rate to what you know about the market.* If you are above market, you may still choose to present this rate as part of your proposal to the provider. Based on variety of factors (e.g., the quality and reputation of your services), you may be positioned to negotiate a higher rate than other organizations and may wish to do so particularly where your true costs are above the “typical” market rate. If you are below market, you may consider building in a margin, or if you have one already, increasing it.
 - vii. *Be realistic.* Business models and budgets should not be based upon reaching 100% capacity or utilization. Ideally, the best case budget should provide significant profit, and the worst case budget should at least break-even. Organizations should plan for multiple scenarios and carefully monitor the actual revenue and expenses against these budgets.
- 2) Having a carefully developed rate is one key step in ensuring that you negotiate the most optimal contract for your organization. Take these additional steps as you negotiate contracts with MLTCs:
- a) *Know your potential business partner.* When starting a new business relationship with a MLTC, conduct adequate due diligence. At minimum, learn the basics about the company (geographic scope, length of time in operation, etc.), but also know their track record and reputation in the field. (Again, colleague organizations can be of help here.) You also want to ascertain if they can deliver the number of clients in the contract, so ask about outreach and enrollment practices.
 - b) *Engage outside assistance in understanding the contract terms.* While contracts with MLTCs use standard contract language, you should consider having a lawyer review the contract. This is especially true if you are unaccustomed to negotiating contracts overall or if these are new kinds of agreements for your organization. This is a good practice even for organizations that have more experience along these lines.
 - c) In the course of your review of the contract, make sure that you are totally clear about the key terms (and implications) of the contract, including:
 - i. *Scope and level of services to be provided.* What types of services and number of potential clients are you committing to serving as part of this agreement?

- ii. *Additional obligations.* In addition to any programmatic expectations, what other obligations are you committing to as part of this agreement? For example, will your agency need to have any new certifications (e.g., HIPAA) to fulfill the agreement?
 - iii. *Financial risks.* In addition to any unforeseen costs (e.g., certifications), what other financial risks may this contract present to your organization? In addition, you should know what the financial implications are if you receive a lower number of referrals from the MLTC, or none at all. Create a worst case budget scenario based on this assumption.
 - iv. *Reimbursement terms.* Make sure that you understand the process and timeline for being reimbursed. What documentation will be required of your organization? What is the turnaround time for payment? Regarding the rate, one question to answer is whether the rate is guaranteed throughout the term of the contract or if it may change (if, for example, state reimbursement rates to MLTCs change.)
 - v. *Additional reporting or “auditing” requirements.* What other reporting requirements may be required of your organization? Will the provider make site visits to audit your programs?
 - vi. *Window for renegotiating contract terms.* This is especially important if this is a new kind of contract for your agency. If any of your assumptions proved inadequate (costs of providing services) or the obligations of the provider were not met (e.g., number of referrals), you will want an opportunity to revisit the contract terms.
 - vii. *Process for managing disagreements.* Make sure you understand how you should communicate any objections or disagreements you have, and how the MLTC can do the same with you.
- d) You may find that the initially proposed contract terms are acceptable, and after close review by you and a lawyer, you may accept the contract as it is initially written. If this is not the case and you propose a counter-offer to the provider, keep the following in mind:

- i. Know what the critical negotiating points are for your organization, especially any non-negotiable items. Examples: the negotiated rate or the number of referrals.
- ii. Be prepared for to ask for everything your organization needs before you finalize the contract. It's better to ask upfront than to regret not doing so later on after the contract is signed. Again, a lawyer can help you articulate and then present these needs to the MLTC.
- iii. You need not enter into a disadvantageous agreement. There is much incentive for both the MLTC and your organization to enter into a mutually beneficial relationship. But, if you believe – through the course of negotiations – that the contract terms are not meeting your organization's needs, then continue to negotiate, or consider engaging with another MLTC.

Just as with any business opportunity, you do have to make a decision within an appropriate amount of time. But you should not sign a contract before you conduct thoughtful planning and undergo a careful review of the agreement, following the steps above.

