

Resource Guide

Pricing CBO Services in a New Health Care Environment

Is your community-based organization (CBO) interested in pursuing contracting opportunities with health care entities, including health systems, accountable care organizations (ACOs) and managed care organizations (MCOs)? Then this Resource Guide on Pricing, which provides guidance on the development of competitive, performance-based pricing models, is for you!

Introduction

The financial landscape for CBOs is changing. As health care systems increasingly become more organized around quality and patient outcomes, a corresponding shift is driving change in the way social services are organized, delivered and financed. This leads to new CBO business opportunities that go far beyond traditional government programs and foundation grants. These new opportunities create significant potential for person-centered collaborations at points of care where social service integration can improve an individual's health and quality of life while delivering positive financial outcomes for the payer.

To leverage these opportunities, CBOs must become comfortable with new ways of financing, measuring and managing their services. Successful CBOs will develop offerings that drive positive outcomes and deliver a meaningful return on investment (ROI) for their health care partners that provide incentives for both organizations.

Financial Contracting 101

Traditionally, CBOs have been paid based on a per-unit fee for a predetermined number of units of services (fee-for-service) delivered to eligible individuals. For example, a CBO receives \$5 per meal delivered to an older adult; if they serve 100 meals a day, the CBO is paid \$500. This type of funding formula has led CBOs to focus on delivering, tracking and reporting units of service. Because there is a

reasonably predictable volume, cost projections do not require CBOs to consider certain factors that will be necessary under contracts with health care entities. Additionally, this funding arrangement typically provides the funds necessary to execute the programs in advance. However, MCOs and health care systems expect contractors to submit a bill *after* services have been provided, and then take up to 90 days to submit payment. CBOs must anticipate this financial management reality as they prepare for these contracting opportunities.

MCOs, on the other hand, are usually paid a fixed amount per member per month (PMPM, also known as a capitation rate), regardless of how many covered services the individual uses or how costly those services are, with the MCO assuming the financial risk. The primary goals of managed care plans are to deliver the covered services their members need to stay healthy, manage chronic and acute health need, and improve the member's health more efficiently and effectively than under traditional, non-managed health insurance structures, including Medicaid and Original Medicare.

Under this type of risk-based scenario, an MCO operating under a Medicaid managed long-term services and supports contract would typically negotiate with the state Medicaid agency to establish acceptable PMPM rates that allow the MCO to pay expected claim costs, administer the plan, pay government fees and taxes and still end up with a small percentage over costs (if costs are estimated accurately and the business model is executed correctly). This financial structure provides strong incentives for MCOs to manage their services efficiently and effectively.

MCOs are particularly motivated by their risk-based contracts to seek relationships with providers who can also deliver services efficiently, effectively and with price predictability. Expect MCOs to enter negotiations with your CBO hoping to find an experienced partner that is willing to offer a value proposition that delivers

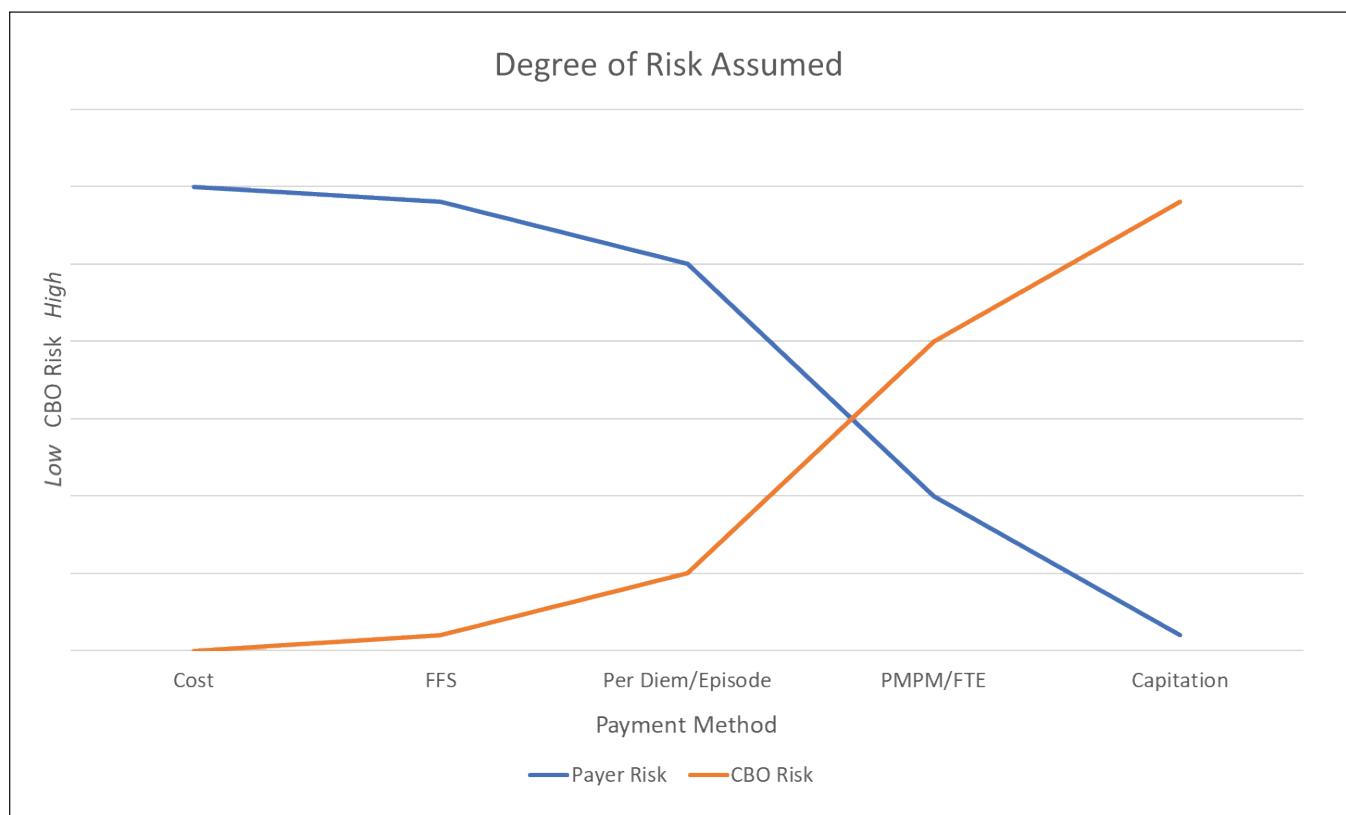
a competitive price and outstanding results. Payment models are varied and each brings different issues and levels of financial risk for CBOs. CBOs that are new to working under these types of arrangements should initially be cautious about working under PMPM, full-time equivalent (FTE) and other contractual arrangements that place significant and variable financial risk on the CBO.

This is especially true of opportunities that involve the CBO securing and paying service providers to deliver unpredictable volumes and hard-to-forecast costs. For example, a CBO shouldn't agree to a fixed rate for services that require taking on the risk of funding service providers on a fee-for-service (FFS) basis where volumes are unpredictable (providing services for the elderly during flu season is an example). If your agency agrees to provide a range of services at a fixed price with an unpredictable (or contractually limited) upper end on the volume (and associated costs), your agency will be exposed to significant financial risk. These types of arrangements are not always bad for CBOs. In fact, a few large agencies with many years of experience and data in this area, plus sufficient financial reserves, may find that fixed price contracting provides an acceptable

opportunity for their CBO. However, most CBOs would be wise to avoid these types of arrangements because of the downside financial exposure. (There's more on fixed and variable costs in Step One, below.)

CBOs have a variety of payment models to consider when contracting with health care partners. These payment models can be viewed as being on a continuum of financial risk. Virtually any payment model has some degree of risk, with cost and fee-for-service models carrying the lowest risk for CBOs with full-risk capitation carrying the highest financial risk. The chart that follows is intended only to provide a representative view of the typical risks associated with frequently used payment methods. Within each payment method, organizational responsibilities assumed by the parties can shift the risk profile based on specific roles and responsibilities outlined in a given contract.

While there are many payment methods that can be used in contracting, the table on page three defines those included in the below financial risk continuum. For those wishing to learn more, the Urban Institute's *Research Report: Payment Methods and Benefit*



Types of Payment Methods	Definitions
Cost	A provider calculates the total amount it spent to deliver one or more health care services for a patient, and the payer reimburses the provider for those costs. ³
Fee for Service (FFS) ⁴	A payment approach in which a specific amount is paid when a particular service is delivered; generally, the payment amount differs depending on which discrete service is delivered. ⁵
Per Diem	A payment that is made for each calendar day on which services are provided to a particular patient—but not on how many services were delivered on each calendar day. ⁵
Per Episode (bundled payment)	A form of payment that covers a defined group of services over a specified period of time. Episode-based payments, paid prospectively or retrospectively, can be made to a single provider or to more than one provider involved with the care episode, in which case the payments can be referred to as bundled episodes. ⁵
Per Member Per Month (PMPM)	A specific, pre-determined payment made by the payer to the provider per assigned member each month regardless of the number, amount or intensity of services provided. While the PMPM payment is fixed, the potential costs may vary significantly based on the type, frequency and intensity of services the provider is contractually obligated to deliver. As a result, a PMPM will shift the risk of this cost variability to the provider. Note that in our chart above, we have assumed a very well-defined, narrow and manageable set of services and predictable variability in provider costs. If this variability rises, the CBO provider's risk will correspondingly increase and vice versa.
Full-Time Equivalent (FTE)-based	A form of compensation in which providers are paid for a specified number of their employees (FTEs) for a defined period of time at a fixed rate per FTE unit. The fixed rate per FTE unit is typically based on a predetermined volume (caseload) adjusted by the required functions and tasks, as well as the FTE qualifications. Example: An MCO contracts with a CBO for service coordination and pays the CBO for five service coordinators who are assigned 70 program participants each (1:70 caseload ratio).
Capitation	Fixed, prospective payment made to cover the cost of care for a defined population over a specified time period. A specific dollar amount per member per month is paid to providers, and in return they provide whatever quantity of services is needed to meet the defined patient population's health needs. (The term capitation means that the payment is made per person, or per capita, rather than per service.) ⁵

*Designs: How They Work and How They Work Together to Improve Health Care; A Typology of Payment Methods*¹ contains a comprehensive discussion of common payment models as well as a useful glossary of definitions. Another excellent resource for

definitions of various payment methods is *The Payment Reform Glossary: Definitions and Explanations of the Terminology Used to Describe Methods of Paying for Healthcare Services*² from the Center for Healthcare Quality & Payment Reform.

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1. <https://www.urban.org/sites/default/files/publication/80316/2000779-A-Typology-of-Payment-Methods.pdf>
 2. <http://www.chqpr.org/downloads/PaymentReformGlossary.pdf>
 3. Miller, Harold D. 2015. *The Payment Reform Glossary: Definitions and Explanations of the Terminology Used to Describe Methods of Paying for Healthcare Services*, First Edition. Pittsburgh, PA: Center for Healthcare Quality and Payment Reform. <http://www.chqpr.org/downloads/PaymentReformGlossary.pdf>.
 4. Berenson Upadhyay DK, Delbanco SF, and Murray R. 2016. Research Report. *Payment Methods and Benefit Designs: How They Work and How They Work Together to Improve Health Care; A Typology of Payment Methods*: Urban Institute. <https://www.urban.org/sites/default/files/publication/80316/2000779-A-Typology-of-Payment-Methods.pdf>
 5. <https://www.nonprofitaccountingbasics.org/reporting-operations/budgeting-process>

We should also note that performance-based or pay-for-performance (P4P)⁵ features may be utilized with any of these payment methods based on the ability (or inability) of the provider organization to meet specified performance standards and goals. A P4P system can provide rewards (upside), penalties (downside), or a combination. They may also be implemented at predetermined points in time (anniversary) or applied prospectively (future payments to the provider are higher or lower based on performance in a prior period). A CBO should use caution and base its willingness to accept risk on its financial strength and its experience with the proposed scope of work.

Remember, while MCOs are motivated to deliver efficient results, they are also measured—and often financially incentivized—for their ability to improve the health of their members while achieving high customer satisfaction ratings. CBOs that can help MCOs in these outcomes-based measures will be in a strong position to negotiate for incentives aligned with delivering positive, measurable results. There's more on quality performance metrics in Step Four, below.

In more mature and organized health care settings, MCOs will offer incentives to partners, including CBOs, that are willing to assume some level of financial risk. Remember, in most scenarios, the MCO is paid on a PMPM (or capitated) basis—and typically has performance incentives—to deliver the services they are contracting your CBO to provide “downstream.” It is worth noting that the expectation will always be for downward pressure on prices. From day one of any contract, it is essential that your CBO measures and implements creative ways to lower costs and improve results for your partner.

Similar scenarios to those described above have long existed for health care providers in traditional employer-based insurance plans and Medicare Advantage plans, and the Centers for Medicare & Medicaid Services (CMS) is moving toward value-based provider incentives in the Original Medicare program, too. For example, ACOs and bundled payment initiatives have grown significantly in recent years and CMS is expected to continue this growth in the future.

These trends are changing financial incentives and performance metrics, moving away from volume or activity-based reimbursement and toward incentives related to efficiency, quality and patient outcomes that reward providers who can track and demonstrate positive results. Fortunately, these incentives align well with the CBO community's long history of providing evidence-based health promotion and disease prevention programs and person-centered objectives.

This resource guide describes four steps CBOs should use when developing pricing models for relationships with health care entities.

Note: Pricing competency is one of many skills CBOs will need before they can assume risk through fully capitated payment rates. CBOs will also require insurance, actuarial skills, experience with managing utilization and costs, etc.

Step One: Understand Your Budget

Understanding your budget is the first step to pricing your services properly. This resource guide does not cover the basics of budgeting as there are excellent existing resources on that topic, including *The Budgeting Process*⁵ from the Greater Washington Society of Certified Public Accountants and the Virginia Society of Certified Public Accountants' *Budgeting: A Guide for Small Nonprofit Organizations*.⁶

To price its services properly, a CBO will need to analyze its costs and model various scenarios. Importantly, a CBO will need to categorize its costs of service into three types: ***indirect costs, direct costs and variable costs.***

Indirect costs (“fixed-sunk costs” or “sunk costs”) are expenses that will be incurred by the CBO regardless of whether the opportunity or contract is pursued or won. These expenses will not be affected by volume. Indirect costs *should not* be included when determining the price. Examples include Chief Executive Officer salary, Human Resources, accounting, rent and existing equipment. Your health care partners will assume that these costs are already covered in your current

6. <http://www.vscpa.com/Content/Files/vscpa/Documents/2011/Budgeting.pdf>

operations and therefore cannot be charged again to your proposal.

Direct costs (“fixed-not-sunk costs” or “fixed costs”) are fixed expenses that will be incurred only if the opportunity or contract is pursued or won. These expenses are directly attributable to the opportunity and will not vary considerably with volume, at least within a definable range. Direct costs *should be* included in the pricing analysis. Examples include new salaried employee hires; vehicles; additional facility needs and technology investments such as software, hardware, phone systems and printers.

These costs may exhibit some variation. If volumes reach certain levels that require increases in these fixed costs, your CBO may wish to consider volume-based pricing to anticipate some of these levels, including volume discounts if appropriate. Examples may include reaching the threshold above which you would need to significantly increase facility size, purchase new technology, or hire additional salaried employees. Discounts would be appropriate where your CBO can spread the costs of, for example, a new software program over a larger volume of clients.

As you perform your analysis, take these potential costs into consideration. However, remember that purchasers generally expect the price to decrease with higher volumes. Do not discourage additional business by increasing prices based on higher volumes to cover these potential “jumps” in your fixed costs. Instead, build these into your pricing model so that your CBO can cover these fixed costs if it is fortunate enough to have its business volume increase.

Variable costs are expenses that increase proportionally with volume. Variable costs must be included in your CBO’s pricing analysis. Examples include hourly wages of administrative staff, social workers, drivers, nurses or case managers; supplies used in performing services; fuel for transportation vans; rental costs for use of a facility to conduct a class or other service; or supplies needed to prepare home-delivered meals.

Full costs are the combination of all three of the above.

You will need to calculate the “**unit cost**” of each service. For simple unit cost priced projects, here’s an easy formula to get you started:

$$\begin{aligned} &\text{Direct Costs} \\ &+ \text{Variable costs (excluding indirect costs)} \\ &\div \text{Quantity of services to be provided} = \\ &\text{Unit cost} \end{aligned}$$

Cost: the amount spent to produce a good or service, or the sum of the value of the inputs in production—labor, land, capital, etc.

Price: the amount of money that consumers have to give up to acquire a good or service; the sum of money asked or paid for a good or service.

Some CBOs have made the mistake of stopping here and equating unit cost with price. However, doing so means your CBO will exactly cover its costs (*if* the unit cost was calculated accurately). So don’t stop there! This is where your knowledge of competitor pricing on similar products and services, as well as market norms, comes into play. Consideration must be given to what needs to be added to the unit cost to cover unexpected costs, inflation, delays, shortages and overages, etc. And what about a margin? If the price you negotiate is above the cost per unit, there will be a positive financial contribution that “contributes” to your agency’s ability to offset its indirect cost, develop reserves and expand your services. To take it to the next logical step, a useful cost-per-unit calculation tool can be found on The SCAN Foundation’s website.⁷ You can also find a free online course on pricing⁸ developed by the SCAN Foundation and the Health Foundation For Western And Central New York.

Additionally, knowing the full cost (including indirect costs) is useful for price negotiations. Indirect costs are vital to ensuring the effective management and growth of an organization. Presenting the full cost to potential buyers is advantageous in negotiations even though an MCO or health care system will only want to pay enough to cover the costs associated with delivering

7. <http://www.thescanfoundation.org/tools-community-based-organizations>

8. <https://zipmart.com/Brand/4/Source/1/Home/Course/56/Description>

the service the organization is purchasing. Full cost may be useful as a starting point in negotiations, but any price above the combination of your agency's direct-fixed and variable costs should be given serious consideration.

Another valuable exercise is to analyze your employee costs; specifically, what it costs to hire and compensate an employee in a particular role. This is often referred to as an FTE (full-time equivalent) calculation. To make this calculation, go back to the cost descriptions above and break those down to the cost of a single employee in a given role necessary to do the work being contemplated. What is the typical wage you would need to pay for that position? Benefits? Technology? Occupancy? Supplies and other expenses associated with the work? Remember, do not include indirect costs or costs that may be traditional in similar work if those costs will not apply to the contract you are negotiating! For example, if your current employees work out of your office but the roles being considered will be based in the hospital, your FTE calculation shouldn't include office space.

Step Two: Build Your Models

Using models can help answer "what if" questions when determining what it will take to achieve promised outcomes for a given price. The models will also help you understand the impact of investments on the unit price of services, identify which investments or cuts will have the greatest effects, determine the required staffing levels, and compare your CBO's costs with those of your competitors. In building your models, follow the steps below.

- a) **Define your services precisely** to be able to answer these questions:
 - What services are required to achieve the desired outcome?
 - What functions are required to perform the service?

- How much time will be required to perform the function?
- What level of staff will be required to perform the function to achieve the desired outcome?
- What other resources will be required (e.g., new computers or software)?
- What might MCOs seek that could add cost to providing the service (e.g., after-hours or weekend availability, or faster than current response times)?
- What costs will you be able to avoid under this proposal compared to traditional opportunities or your current contracts?
- What is the value added to the MCO and how will it positively impact their bottom line?

Define the budget assumptions. Your assumptions are estimates based on your experience and research about how your CBO conducts business. Examples: caseload will be 75 clients to 1 care manager; fringe benefit rates will be 28 percent;⁹ inflation rate will be 2.8 percent (Bureau of Labor Statistics); and a 5 percent contingency will be added to cover risks.

- b) **Build the model(s).** Entering your data into a spreadsheet turns your assumptions into numbers. Your volume will drive the variable costs so it is important to understand how the volume of service will impact the price. Then change some of the assumptions. Examples: What if we staff a program with a licensed social worker instead of a registered nurse? What if we increase caseload sizes and hire lower-level assistants to optimize the time licensed staff spends doing work at the top of their license? What if we can lengthen the contract period to allow our organization to amortize the cost of that new computer system over a longer period of time?

9. Note for government-based CBOs: Fringe benefits are an area where many government-based CBOs struggle to be competitive. Some government agencies are required to add fringe and indirect cost rates that are uncompetitive in comparison to private-sector competitors. If your agency faces this situation, start the conversation early with your government liaison to look for ways to creatively address this issue. In some areas, government agency costs may be considerably lower than private sector cost structures and you may be able to develop a total price with a competitive net cost to the MCO or health care system. The key is to do your homework and understand how your agency stacks up against potential competitors.

Step Three: Make the Business Case

The definition of a business case is the justification of an organization's (the buyer's) expenditure based on the positive economic consequences to the buyer.¹⁰

To make a business case, CBOs and other providers will need to *demonstrate evidence of financial value to their MCO payers*. The business case involves a cost-benefit analysis. The benefits must be expressed in dollars.

One way CBOs can describe the value of a service for the payer is to articulate the *impact on cost avoidance* (e.g., keeping the individual out of the emergency department and/or hospital). Examples well known to many CBOs include: nursing home diversion programs, respite care, care coordination, care transitions, evidence-based programs, palliative care and person-centered care.

To negotiate effectively with MCOs, your business case must address the question, “Is there an adequate **return on investment?**” In other words, will your proposal lead to a measurable financial benefit for the MCO? To calculate your ROI, take the following steps.

- Calculate “gross” benefits by measuring and totaling the expected benefits in terms of cost savings plus any revenue enhancements.
- Estimate the total costs of the program.
- Subtract the total program costs from the “gross” benefits to get “net” benefits, which are often expressed as a percentage of the program costs and called return on investment.
- The ROI is compared to a “hurdle” rate: a minimum percentage that any investment must generate to be considered. The payer probably has several options for investing its finite capital resources, so it isn’t enough to simply show an ROI. You must have an ROI that is attractive to the payer when compared to your competitors and alternative investments.

Medicaid and Medicare pricing: What MCOs are willing to pay CBOs will often be dictated by state Medicaid (or federal Medicare) budgets and payment policies. Remember, the MCO or health system must be able to deliver cost savings to the government. This is difficult to accomplish if the MCO is paying your CBO more than the government agency would have paid you via a direct contract. That is why MCOs often follow the local Medicaid program fee-for-service rates, but it is *important to understand that MCOs have flexibility to negotiate different rates, based on your value and the business case you present.*

Step Four: Quality Performance Metrics

For MCOs and other health care providers, value-based incentives—and penalties—are a reality. These incentive systems require providers to prove that they’re meeting a set of quality standards and benchmarks. Your CBO will be expected to track its performance—not in terms of the units of service delivered (fee-for-service model), but on the health outcomes it has achieved (payment for value) and other quality and satisfaction metrics. You should begin now by researching the metrics your potential partner may be facing. For example, are there quality standards and benchmarks that the state Medicaid agency has included in their Request for Proposal or a sample MCO contract? These are often publicly available documents.

Understanding what measures motivate your potential partners is key to determining which quality measures make sense for you to focus on and which measures should become a point of emphasis in your business case that you can use to demonstrate financial value to your MCO payers. You can find more information about the quality measures MCOs use, including definitions and financial incentives in our resource guide, “Health Care Quality Metrics and Measures,” which is available on our website.¹¹

10. From “Preparing Community-Based Organizations for Successful Health Care Partnerships: How to Make the Business Case,” part of the National Aging and Disability Business Institute Webinar Series with Victor Tabbush, Ph.D.

11. <https://www.aginganddisabilitybusinessinstitute.org/>

After your CBO has analyzed its budget (Step One, above), determined and negotiated a reasonable price (Steps One and Two above), and managed and delivered favorable results for an initial contract period, it may want to consider entertaining incentives or bonus targets as a value-based payment, based on your achievement of quality measures. If you consider adding incentives, make certain those initial incentives are positive incentives or that any negative incentives (e.g., “withholds”) are financially manageable for your organization. It’s good to think optimistically and set stretch goals, but be certain your CBO’s financial plan is based on an acceptable outcome for your CBO in the event that it doesn’t hit its metrics and the negative incentives come into play.

CBOs are encouraged to start slowly and partner with MCOs and health care providers in a way that allows both organizations to learn and grow. The future trend will be more value-based provider payments. While the rewards for success can be great, there are risks for CBOs that move to risk-based arrangements too quickly.

It would also be wise to implement a quality-improvement culture and continuous planning process. One tool that can help with that is the Plan-Do-Study-Act (PDSA) model.¹²

How One CBO Used Value-Based Payments to Achieve Results

One CBO negotiated an innovative contract with an MCO, called a “case rate agreement,” for a group of clients with serious mental illnesses. The CBO committed to reduce repeated hospitalizations for these high-cost Medicaid beneficiaries. With new PMPM capitated payments, the CBO could change its model of care to produce results. The CBO documented lower MCO costs and better outcomes with this new model of care, including: a 53 percent reduction in emergency department visits, a 50 percent reduction in hospital admissions, and a 55 percent reduction in 30-day readmissions. The data on positive health outcomes resulted in an expanded case rate agreement to all the MCO’s members served by that provider.

Now that your CBO has completed the four steps for developing a competitive, performance-based pricing model contained in this resource guide, it is ready to pursue relationships with health care entities such as health systems, ACOs and MCOs. Good luck!

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12. <https://www.aginganddisabilitybusinessinstitute.org/resources/plan-study-act-pdsa-cycle/>