

January 29, 2018

9:00AM – 11:00AM

Tom Fox Chapel – Main Building, Concord NH

Meeting: Performance and Value Based Contracting and Payment Process (NH Business Acumen Sub-Committee)

Facilitator: Sandy Hunt

Note taker: Maureen DiTomaso

Attendees: Sandy Hunt
Bethany Earls
Carolyn Virtue
Denise Doucette
Ellen McCahon
Jebb Curelop
Kerry Pfrimmer
Kim Shottes
Le'Ann Milinder
Mary St. Jacques
Maureen Rose Julian
Michelle Donovan
Nancy Rollins
Sarah Aiken
Shelley Kelleher
Tim Leach
Tom Bunnell
Tracey Tarr
Wendi Aultman

Minutes

Agenda item: Housekeeping / Introductions

Presenter: Sandy Hunt

Performance and Value Based Contracting and Payment Process (NH Business Acumen Sub-Committee)

January 29, 2018 Meeting Minutes

Page 1 of 6

Discussion:

Sandy projected a PowerPoint presentation which outlined the definition of Business Acumen; Overview of National Association of States United for Aging and Disabilities (NASUAD); New Hampshire's overall aim and what today's sub-committee's focus should be.

There were additional handouts available which outlined Managed Long-Term Services and Supports (MLTSS) toolkits for assessments, and self-assessments. Also there was a handout for Administration for Community Living (ACL) contracting life cycle self-assessment. These handouts were made available to the members of this sub-committee group to assess the business acumen of their own agencies and to determine their agency's priorities.

Today's focus for the group is to brainstorm regarding determining strategies or metrics which will help New Hampshire move towards having a performance based and value based contracting and payment process. Value-based programs reward providers with incentive payments for the quality of care they give to individuals on Medicare and/or on Medicaid.

A goal of this sub-committee is to be a learning collaboration, to brainstorm and come up with ideas which the Department can bring back to NASUAD.

Questions and comments from sub-committee members:

- When reviewing the systems currently in place, will the review go beyond Information Technology (IT)?
 - Yes, we want to look at our processes, what are different ways to communicate, and the technical efforts within IT.
- Concerns were raised regarding Area Agencies (AA) dealing with the unique aspects of individuals and families. If there are performance based measures could AA then be put into situations where they feel they need to force an individual / family into situations which they make not want or may not work best for them specifically. Example given if a particular family had an individual at 30-years old who did not want to have a job. But if a performance measure is based upon employment, we don't want to try to force an individual into something they don't want to do you don't want to take away choice in order to meet metrics.
 - Maybe we need to stay away from the areas of service delivery when we look to develop the metrics.
- Previously when funding for AA was broken down by metrics, some AA would reach those metrics in order to get more funding, but at the same time, they may not have been thinking of every aspect of an individual's needs. We need to make sure to look at who we are serving and how to best serve them.
- There are many differences between our older population and the younger population. There are different needs for different transitions.
- Whatever metrics we come up with we should make sure that they focus on what we all value most about our system, not just what is easiest to measure.
- We could look at The Council on Quality and Leadership (CQL) Personal Outcome Measures tool.
- Some AA and providers are accredited. Becoming accredited is very labor intensive and expensive and there is a lot of follow-up work to maintain your accreditation. But the overall experience has been good so far. There are a number of interviews done from the top down, from providers, life coaches, individuals and/or families. Some providers may have accreditation because it is required in other states where they have companies. This group could look at some of the measures looked at for accreditation.
- We want to make sure that we capture the relationships and/or personal outcome measures.

- There are many ways that data is already being collected. We want to make sure that the metrics we come up with will not have unintended consequences downstream.
 - Sandy discussed a software demo she was recently a part of, where information is entered into a database and you can see a statewide view of where specific issues are happening. If we can identify specific areas maybe with can offer trainings, or additional help. This type of tool could be very valuable.
- A challenge is when it comes to the delivery of medical care; there are clearly understood measures that everyone agrees to. It is very hard in this type of domain to determine what the quality measures are. There are no nationally endorsed benchmarks.
 - National Core Indicators (NCI) Surveys could be a good measure.
- Choices for Independent (CFI) waiver comes from a more medical model where the DD (Developmental Disability) / Acquired Brain Disorder (ABD) waivers are more based on quality of life or community based models. What metrics could we look at from CFI, ABD, and DD?
 - Bureau of Elderly and Adult Services (BEAS) is currently conducting a quality survey. Not sure what the indicators are.
 - The CFI waiver model has changed based upon who has been in the Administrative position. Sometimes it was more of a social model and other times medical model. From experience the CFI waiver is a combination model that has served the state very well. Consumers are served without any real medical intervention, more personal care services which are consumer directed. The majority of individuals on the CFI waiver are dually eligible, but if you do not have the medical component, you cannot maximize the skills / resources.
- Is there anything within the aging population service delivery system which is designed to measure performance?
 - Some agencies look at the outcomes, are we going to use the definition of community based organizations (CBO)?
 - Some CBOs which deliver CFI do not hold contracts which indicate what services they will deliver, but based upon what the regulations state.
- How do we make value based contracting work for both populations?
 - At the Federal level there is talk about outcomes measures at three (3) different levels. System delivery outcomes, Older Americans Act, and individual levels. We also look at No Wrong Door. It's not just focused on the individual but as a system and how to put value into the system. It's broad.
- There is more oversight within the CFI system than what most people understand. Most providers need to be licensed, certified, there are also mechanisms in place for on-site surveys. There is most likely data that the state has collected which hasn't been used. It would be interesting to see a combination of the surveys.
 - Agencies that are not credentialed are reviewed under other guidelines.
 - Case Management organizations are under the Quality Survey. DHHS physically comes out to offices for three (3) days. It is time consuming to comply with all mandates. We need to recognize information that is already gathered.
 - Managed Care Organizations (MCOs) have looked into certification for case management services.
 - It is very expensive and that money is a percentage of the revenue. Need to do more about the 20% rate.
- Also we need to remember some agencies are for profit and some are non-profit. When you have an objective to lower costs, you get into the waters of how much money can an agency make. If you change the financial metric you have to be careful that you're not saying what the profits can or cannot be.
 - It is important to circle back to the integrity unit. What metrics are being looked at such as risks based on financial condition within that agency? We do not want to attach value, but contract conversations might be a little different, how to apply that to a value based system.

- There are usually 2 principles which are to lower costs and increase quality. There are still institutions which have a higher level of care than for individuals served in the community. When we think of the DD system, there are no institutions, so therefore costs are already low. What more can they do? Especially when the pay rate for Direct Support Professionals (DSP) is so low? If agencies need to find quality DSPs who have college educations, we cannot afford them.
 - Maybe the questions should be about not lowering gross expenses but to bend the trends. Look at growth rates, create better programs. There are different ways to define “lowering costs”.
 - If the objective is to lower the costs trends, costs could go up by 3% but that cost curve could be bent through better integrative care, earlier interventions,
 - Example on the CFI waiver, outcomes may score dynamically. Example Ms. Jones was in the hospital for 200 days out of the year, but since being put on the CFI waiver, she has had zero hospitalizations. If we scored outcomes like that it would be huge. But if you just look at the costs of being on the waiver, it’s expensive, such as 30 hours of care. But no way to look at what being on the waiver may have prevented.
- Look at an incident of concurrent diagnosis, if there had been earlier interventions, how might that affect the budget when turning 21? It’s another thing to think about.
 - Health Risk Screen Tool (HRST) did a presentation where as a high HRST score could predict mortality.
 - We could start to look at data we already have and utilize ways to create preventative measures.
 - Spending in Medicaid dollars savings, example if someone goes to the Emergency Department (ED) they will no longer be on the AA radar. That individual might have a \$5K hospital stay which could have been prevented had we had measures in place to predict it!
 - There should be ways to follow individuals through acute Skilled Nursing Facility (SNF) stays, back to Long Term Care (LTC). Maximize Medicare benefits upon discharge back home. Is anyone scoring or understanding the interventions? Many times there are mechanisms in place which prevent care from being delivered adequately.
- New Hampshire is a small state. There is a large variability. When there is a large population, metrics are measureable, but within small populations one (1) or two (2) individuals within a region can skew the numbers. There could have been no changes within quality, but we need to remember to factor this into the metrics.
- If this group could come up with examples and definitions we could look at lowering costs on a broader spectrum. Some examples would be if there was more done during Early Supports and Services (ESS) could we have been more prepared. We need to focus on capitalizing on the strengths of different programs.
 - This could include looking at the school systems more closely.

When first proposal was submitted the Bureau of Developmental Services (BDS) only had the DD / ABD waivers. With the restructure of the Departments where BDS combined with BEAS to become the Division of Long Term Supports and Services so now this proposal will include the CFI waiver. The CFI waiver will NOT be going through the Area Agencies. When we look at metrics we could separate them out. We realize that there are differences between the waivers. As we develop outcomes and metrics this group needs to keep in mind that it will depend on what population is being served.

Area Agencies do have contracts and there can be something learned from those redesignation exercises and other federal funds which revolve around outcomes. It’s a learning process for this group to have conversations.

Discussion:

Sandy passed out a priority area worksheet.

Sandy discussed the Provider Selection (Request for Proposal (RFP)) sub-committee group which she feels could feed into this group. That sub-committee is thinking of somehow developing a provider report card so that individuals/families will have a better informed choice. They could have the ability to look at the performance of the providers which are important to them.

- Are Area Agencies still geographical?
 - Yes, although if you want to go through a different AA there are processes in place to allow individuals to do so if the receiving AA is agreeable.
- Why have they not looked at the percentage of non-served or under-served populations throughout the state? Shouldn't that be more of a priority to discuss that issue?
 - That is a great point, but it is a bigger issue. The Utilization Review (UR) subcommittee will look at ways to identify ways to measure if services are being utilized efficiently.
 - Our system works within a budget and how we manage services within that budget. There's no question that those individuals who need services will require more funding. But this subcommittee's goal should be how to work within the system we have now.
- There is an expectation that college educated individuals will provide services, but the AA cannot hire those individuals given the pay rate we have. Centers for Medicare & Medicaid Services (CMS) need to hear this. We'll just go around hiring the same people and expect a different outcome.

What we need to do in this group is find two (2) to three (3) things which are not dollar related but instead related to quality.

New Hampshire does have one of the lowest unemployment rates. But the older population is presenting challenges. The Business Acumen Learning Collaborative is a technical assistance grant, with no money attached to it. NASUAD want to hear from us regarding our concerns and they want us to be part of the conversations.

“If you're not at the table, you're on the menu” – unknown

In 2010 Matthew Ertas did a slide deck which attempted to predict out the number of participant managed and directed supports. We are nowhere close to that number. But maybe we can awaken the vision and see how we could get there.

Participant Directed and Managed Services (PDMS)

- Would be curious to see if the UR subcommittee was to look at the effectiveness of PDMS. While families like the idea of it, being so difficult to utilize and quality sometimes isn't there.
- While the utilization of services may be down, it is most likely because you cannot find providers to serve individuals.
 - This is true for the CFI waiver as well.
- We need to look at the real reasons why certain costs are less, how much quality are individuals or families giving up. Example, if consumers are faced with losing a hands on caregiver, sometimes they will ask if they use less hours could the pay rate be increased. We don't want consumers to forgo care that has been approved for them.
- Michigan is 100% PDMS
- Suggest having more flexibility will allow for more sustainability.
- PDMS wage is higher than that of day programs or caregivers.
 - We need to make sure families are aware of how to supplement budgets.

- What would be a metric which would provide for all waivers (CFI, DD, and ABD)?
 - Due to the Corrective Action Program (CAP) plan there will be restructures on how our systems operate. So this conversation may be a bit premature.

We do not want to burden providers. We want to reward providers for good performance, keep this in mind when coming up with metrics and outcomes.

While some of us are looking at this from a CBO level, let's not forget to also look at this from an individual's/personal level. What does quality of care really mean to them?

Another idea for this group is to determine some basic "best practices" being done and how to make sure that they are being utilized and are impactful.

Conclusions:

To begin this subcommittees' work, we would like to first determine what data is already being collected. Once we know what data is already being collected we can then have something more specific to drill down into for metrics. We can then determine what might be consistent across the board.

Action items	Person responsible	Deadline
✓ Stakeholders will go back to their agencies/companies and find out what information is already being collected and reported on.	All Members of sub-committee group	March 5, 2018
✓ Check BDS website to see if information from the Governance Audits are available to view	Sandy Hunt	March 5, 2018

Attachments:

- PowerPoint Presentation
- Priority Areas worksheet
- MLTSS Toolkit handouts (2)
- ACL Business Acumen: Contracting Life Cycle Self-Assessment handout

MEETING SIGN-IN SHEET

Project: Performance & Value Based Contracting & Payment Process

Meeting Date: January 29, 2018

Facilitator: Sandy Hunt

Place/Room: Tom Fox Chapel

Name	Please check here if attending
Adrienne Evans	
Bethany Earls	Bethany Earls
Cindy Robertson	
Ellen McCahon	Ellen McCahon
Jebb Curelop	JEBB CURELOT
Kerry Pfrimmer	K. Pfrimmer
Kim Shottes	Kim Shottes
Le'Ann Milinder	Le'Ann Milinder
Lisa Hinson-Hatz	
Mary St Jacques	Mary St Jacques
Maureen Rose Julian	
Michelle Donovan	Michelle Donovan
Nancy Rollins	Nancy Rollins
Richard Jeffcote	
Sara Blaine	
Sarah Aiken	Sarah Aiken
Shelley Kelleher	Shelley Kelleher
Sue Bagdasarian	
Tim Leach	Tim Leach
Tom Bunnell	Tom Bunnell
Tracey Tarr	Tracey Tarr



State of New Hampshire- Bureau of Developmental Service



**Division of Long Term Supports and Services
Business Acumen Learning Collaborative**

Performance and Value Based Contracting: 1/29/18



Utilization Review Subcommittee - Session 1 - 1/19/18

- Housekeeping / Introductions 10 Min
- Review of NASUAD and NH Overall Aim 20 Min
- Review of NH's Proposed Outcomes 20 Min
- Discussion 60 Min
- Next Steps 10 Min



Business Acumen is...

...Keeness and quickness in dealing with and understanding a business situation in a manner that is likely to lead to a good outcome.

Follow the attached link to access a toolkit which includes Managed Long Term Supports and Services assessments which will help you assess the business acumen of your agency. Complete the self-assessment to determine your agency's priorities:

- <https://www.aginganddisabilitybusinessinstitute.org/resources/managed-long-term-services-supports-mltss-toolkit-assessments/>



Goal/Vision: To build the capacity of disability community organizations to contract with integrated care and other health sectors

Improve the ability of disability networks to act as active stakeholders in the development and implementation of integrated systems within their state

Build capacity, foster collaborative relationships, and engage stakeholders to encourage development and implementation of integrated systems within their state.



- Key Activities:** To develop baseline knowledge of current community based organizations (CBOs)
- Provide training and technical assistance for disability networks to assist them in building capacity
 - Provide technical assistance using learning collaborative model
 - Engage integrated health care organizations, managed care plans and other health care entities regarding needs of service recipients and role of CBO



Anticipated Outcomes: Increased knowledge of CBO successes, challenges, needs, and promising practices

Increased technical assistance and business acumen resources to support CBOs

Increase in learning collaborative participants' business capacity to engage with integrated health care networks

The improvement of health care entities' awareness about the role CBOs can play in the health care system



New Hampshire's Overall Aim

To strengthen and prepare New Hampshire's Long Term Supports and services system, including, but not limited to Community Based Organizations (CBOs), the Bureau of Developmental Services (BDS) and the Bureau of Elderly and Adult Services (BEAS) for the evolution of integrated, high quality and efficient services for individuals in need of support.



TODAY'S FOCUS (priority area #1)

Move to a performance based and value based contracting and payment process. This will make payments more predictable for CBOs and the Division of Long Term Supports and Services (DLTSS). This will hold CBOs accountable for performance with meaningful quality and financial measures



What is Performance and Value Based Contracting?

9

Value-based programs reward providers with incentive payments for the quality of care they give to people with Medicare and or Medicaid.

These programs are part of CMS' larger quality strategy to reform how health care is delivered and paid for. Value-based programs also support CMS' three part aim:

Better care for individuals

Better health for populations

Lower cost

Source: CMS.Gov – Centers for Medicare and Medicaid Services



Proposed Business Outcomes:

- By April 30, 2018, financial metrics will be developed to monitor business effectiveness.
- By June 1, 2018, all area agencies and BDS will be trained on the financial metrics.
- Beginning July 1, 2018, area agencies will be measured using the financial metrics.
- Beginning July 1, 2019, the financial metrics will be incorporated into the area agency contracts.



Proposed Organizational Outcomes:

- By April 30, 2018, quality metrics will be developed to monitor quality.
- By June 1, 2018, all area agencies and BDS will be trained on the quality metrics.
- Beginning July 1, 2018, area agencies will be measured using the quality metrics.
- Beginning July 1, 2019, the quality metrics will be incorporated into the area agency contracts.



Where do we begin?

See Strategy and Action Steps Worksheet

- What metrics currently exist, both financial and quality? Is there a way to organize the collection of CBO performance for these metrics and tie it to contract payments?
- What are other metrics that might be appropriate?

Do these metrics offer better care for individuals? Do these metrics result in lower cost of care? Other thoughts?

Examples from DD/ABD and IHS: Provider Selection Subcommittee – developing a statewide process to identify provider agencies to deliver waiver services. Potentially develop statewide Provider report card?

State agency discussion on implementation of 525 contracts (Participant Directed and Managed Services) and comparison of performance statewide.

Governance Audit: Three year review of Area Agency performance as required by annual contracts was just published and shared with Area Agencies. Audit tools are being revised and reformatted.



Next Steps

Strategies / Action Steps – See handouts

Next Meeting Date: _____



Priority Areas:

Priority Area #1: Move to a performance based and value based contracting and payment process. This will make payments more predictable for CBOs and the Division of Long Term Supports and Services (DLTSS). This will hold CBOs accountable for performance with meaningful quality and financial measures

Strategy A:

Levels of Success:

- Exceeds:
- Expected:
- Minimum:

Action Plan		Additional Considerations			
Action Step	Person(s) Responsible	Date to be Completed	Resources Available / Required	Potential Barriers / Solutions	Collaborators

Strategy B:

Levels of Success:

Exceeds:

Expected:

Minimum:

Action Plan		Additional Considerations			
Action Step	Person(s) Responsible	Date to be Completed	Resources Available / Required	Potential Barriers / Solutions	Collaborators

Strategy C:

Levels of Success:

Exceeds:

Expected:

Minimum:

Action Plan		Additional Considerations			
Action Step	Person(s) Responsible	Date to be Completed	Resources Available / Required	Potential Barriers / Solutions	Collaborators



MLTSS TOOLKIT: ASSESSMENTS

This module provides information and tools to help community-based organization (CBO) leaders assess their agency's readiness to offer vended services to managed care organizations (MCOs), hospitals, and other payers.

The module is designed for the CBO leader to answer a series of questions and complete two assessment tools to gain a basic understanding of the business and operational requirements necessary to operate effectively in the competitive, managed long term services and supports (MLTSS) space. Upon completion, CBO leaders should have completed a basic assessment of the organization's strengths and readiness, identified its most marketable programs and services, and developed an understanding of the organization's weaknesses that must be addressed.

For success with this module, complete these three phases:

1. Review the list of **questions to consider** in the "Getting Started" module. Your answers to these questions are critical to making fully-informed business decisions as you begin the assessment process;
2. Similar to the Getting Started questions in number 1, answer the following self-assessment questions; and
3. Complete both self-assessment tools (see links under "Next Steps" at the bottom of this page).

Self-Assessment

To be successful, you need to look at your strengths as well as gaps. What does your organization do as well or better than anyone else in your area? Where do you have the potential to be a market leader and to build upon your strengths?

1. **Leadership team:**
 - Are they ready for a competitive world where you are the vendor?
 - Are there holes in your current structure? For example, do you have an experienced marketing leader? a fiscal team member who can support your cost model?
 - Does your team need training on working with the private/business sector? Healthcare terminology?
 - Does your staff understand the market changes your CBO is facing? If not, now is the time to begin that dialogue. Help them understand the value of new revenue sources to help your agency achieve its mission. They need to understand why culture change is necessary and this is an exciting opportunity to increase your CBO's ability to pursue its mission.
2. **Service strengths:**

- Can you identify the services each payers needs? For example, if you have a nutrition program that has demonstrated results in lowering hospital re-admission rates, that's likely a service in which hospitals and MCOs would be interested. On the other hand, a program to connect seniors to schools as volunteer tutors – while valuable to the community – is likely to be viewed by the MCO as outside of their business objectives.
 - Can you demonstrate a projected ROI for the potential payor? Why should they care about your program or service? Do you have outcomes or costs savings data you can provide to the payor? If not, can you develop a value proposition and start bench-marking?
 - How quickly can you negotiate and expedite a contract? Do you have signing authority? If not, Are those who have to review and approve the contract on board with your direction?
 - Can you operationalize the project and scale to meet the payor's expectations?
3. **CBO Board and Organizational Structure:** Review your organization's structure, by-laws, and governmental rules about business activities that may be considered inappropriate for organizations like your CBO. This is especially important for local governmental and regional CBOs. If you find a concern, explore your options (we'll cover some of them in a later module).
- Is your Board ready for vended service offerings? Do you have their support? If you have an Advisory Council, the same applies to that group as well. Your Board members have the ultimate responsibility for the CBO and they will want to be certain this is the best direction for the organization and the organization's clients.
 - Don't get too far out front of your Board. If you worry that your Board may have concerns, begin building your business case for them and engage them in the discussion and the assessment. Recognize that, in many instances, the individuals on your Board come to the Board as representatives of their employer or government agency. Think about how those organizations will be impacted by these changes.
 - You may want to include representatives from healthcare entities on your board (hospitals, physician groups, etc.). Lawyers and other business professionals on your board may also be helpful as you engage in some of the new opportunities available. As you consider the Board's membership, keep in mind that some of these organizations (hospitals, health plans, etc.) may be coming to you for services. That can be helpful in negotiations because they will be familiar with the value your CBO delivers. However, what if you are also talking with their competitors? That's not necessarily a bad thing, but it is something that you should consider and plan for and be mindful of anti-trust and laws prohibiting collusion.
4. **Financial Competitiveness:**
- Are you an efficient provider with competitive product/service costs?
 - Are you able to align your direct and indirect costs to compare and explain to the payer?

- Can you use this as a baseline to assess your competitive position and develop a pricing strategy for future opportunities?

5. Marketplace:

- Should your CBO offer Care Transition services to hospitals, transportation to Medicaid Managed Care plan recipients, Chronic Disease Self-Management Programs to Medicare Advantage plan enrollees, or something else? How should I approach pricing? Who might be interested in “buying” these services? Who are my competitors? An environmental (or “market”) assessment, part of the ACL and n4a assessment tools below, will help you answer these questions.
- Under managed care, your marketing plan must include an assessment of competitors and a focus on developing a return on investment (ROI)-based value proposition. This needs to be in a quantifiable, communicable format. It does not need to be exhaustive, but you do need to understand your strengths and weaknesses compared with potential competitors and what the market needs now, and in the future.
- Have you identified the key elements of your market assessment, including market size, market growth rate, market profitability, market trends and success factors related to the goods or services you propose to deliver?
- Who are your potential customers? What do they want and need? What can you offer them to satisfy those needs, and what price is the market willing to pay? On the last question here, do some research on your current state Medicaid rates. That will give you some idea what payors will consider a reasonable price.

6. Future Growth Opportunities: What home and community-based services will be needed in two years, five years, or ten years in your market? CBOs will need to be strategic in formulating decisions regarding future growth opportunities and building new revenue streams. Take time now and identify strategies to:

- Focus your service delivery options on those that will deliver value and be needed in the future.
- Build awareness across the community of the knowledge, expertise, and history you possess.
- Leverage your organization’s relationships and intellectual capital.
- Identify potential business partners and learn everything you can about their business needs.
- Get to know and offer your assistance to policymakers who will be shaping the future “rules of the road”. In most cases, you have valuable experience and insights that can help them make good decisions. In most cases, they need and will welcome your help!
- Make connections and share your value proposition (more on this in a subsequent module) so potential business partners have the opportunity to understand the value of developing a business relationship with your CBO.

In order to assess the current market effectively, a familiarity with strategic business approaches widely utilized by MCOs and other large and small business across the private sector is helpful. For

example, the *Porter Generic Strategy model* (see link on the **Resources** page) suggests a focused strategy that could allow your CBO to seek a narrow, targeted market segment through low prices or a unique offering. Through this narrow strategy, a CBO should be able to control costs by concentrating efforts on a few key products aimed at specific consumers or by building a specialized reputation within a niche market. The Porter model, as indicated in the figure below, suggests that a small firm (or CBO) can profit by concentrating on a competitive niche, even though its total market share may be low. An organization, therefore, does not need to be large to do well. It is through this type of approach that countless numbers of small business thrive in the face of large international conglomerates.

Next Steps:

Complete the [ACL self-assessment tool](#). It is designed to help you identify your strengths and weaknesses and develop a plan to address them. Additionally, when you reach Section I, Assessment 10, stop and complete the [n4a self-assessment tool](#). This one-page assessment tool is designed to help you survey your existing and potential program and service offerings and identify your most attractive product offerings and complements the ACL tool. Use the blank rows across the bottom to add additional offerings as needed.

Conclusion:

At this point, you should have completed both assessment tools and have a basic roadmap of where your agency is today, questions you need to answer, and a high-level roadmap for moving your agency forward.

Future Toolkit modules will help with pricing, contracting, systems, and other specific considerations necessary for success. The journey has begun!



ACL Business Acumen: Contracting Life Cycle Self-Assessment

Phases and Steps	Achieved and ready to share lessons learned with others	Making progress but not ready to share	Just beginning and may need help	Haven't started yet; Definitely need help	Additional Notes
Phase I: Pre-Engagement					
1. Complete internal assessment to understand current strengths and weaknesses <ul style="list-style-type: none"> a. Services that the organization has the capacity to deliver b. History of delivering said services c. Organizational stature in the market d. Political factors impacting the ability to deliver service <ul style="list-style-type: none"> i. Political allies ii. Political foes e. Market allies f. Market foes 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Develop a plan to address weaknesses <ul style="list-style-type: none"> a. Assess what is needed to increase internal capacity to deliver services b. Determine internal weaknesses that prohibit organization's ability to deliver and expand on key services c. Determine what is required to address weaknesses <ul style="list-style-type: none"> i. Understand what weaknesses that can be addressed internally ii. Understand the weaknesses that will require external support to address iii. Assess your ability to seek and secure external resources to address identified weaknesses 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Phases and Steps	Achieved and ready to share lessons learned with others	Making progress but not ready to share	Just beginning and may need help	Haven't started yet; Definitely need help	Additional Notes
3. Determine what is required to address organizational weaknesses <ul style="list-style-type: none"> a. Need for organizational change b. Assess appetite for change from board, leadership and staff. c. Determine what is required to complete organizational change d. Develop a timeline with milestones to initiate the culture change process 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Complete assessment of subcontractors and partners to deliver services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Identify the legal structure or structures that are required to compete in the market place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Research potential legal structures that could work for your organization or coalition, taking into account existing operational structure, your ability to contract for services, and the capacity of your subcontractors and market partners. <ul style="list-style-type: none"> a. Determine the viability of each option b. Evaluate the positive and negative factors of each viable option in terms of how each potential structure fits in with your entity's internal assessment. 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Phases and Steps	Achieved and ready to share lessons learned with others	Making progress but not ready to share	Just beginning and may need help	Haven't started yet; Definitely need help	Additional Notes
<p>7. Complete a Market Assessment</p> <ul style="list-style-type: none"> a. Identify Payers for services <ul style="list-style-type: none"> i. How many payers are in the market ii. Is the market segmented iii. How is the payer compensated iv. What is the level of compensation that the payer receives v. What level of risk does the payer have vi. What services are required for the payer to deliver vii. What services are optional for the payer viii. What are the quality requirements of the payer ix. How has the payer performed on the quality measurements in the past x. What is the position of the payer in the marketplace b. Identify Consumers of services <ul style="list-style-type: none"> i. Determine the necessity of services ii. Determine if the consumer is also the payer iii. Determine the value of the services to the consumer c. Assess availability of services in the market d. Assess marketplace for potential competitors and threats in the marketplace e. Understand political factors that are market drivers 	□	□	□	□	
<p>8. Determine gaps in the market place</p>	□	□	□	□	



Phases and Steps	Achieved and ready to share lessons learned with others	Making progress but not ready to share	Just beginning and may need help	Haven't started yet; Definitely need help	Additional Notes
<p>9. Determine your organization's capacity to deliver services that are needed in the market</p> <ul style="list-style-type: none"> a. Health Information Technology requirements <ul style="list-style-type: none"> i. Core data elements identified ii. Ability to securely transfer information to other entities b. Ability to bill for services c. Ability to track quality of services <ul style="list-style-type: none"> i. Understanding/incorporating payer quality systems (i.e. star quality ratings, reporting systems, etc) ii. Quality tracking must include both process evaluation and outcome evaluation measures 	□	□	□	□	
<p>10. Marketing/Marketing Plan</p> <ul style="list-style-type: none"> a. Develop a menu of services that you would like to offer to the marketplace b. Develop a marketing plan to market said services to the marketplace <ul style="list-style-type: none"> i. Marketing strategy should address potential payers and consumers of said services ii. Marketing strategy should emphasize your history in the market, relationship with the consumer, political allies, and promote the proposed legal structure required to deliver said services c. Develop a value proposition for your services based on the needs in the market and status of competitors <ul style="list-style-type: none"> i. The proposed value proposition must include price. 	□	□	□	□	

Phases and Steps	Achieved and ready to share lessons learned with others	Making progress but not ready to share	Just beginning and may need help	Haven't started yet; Definitely need help	Additional Notes
<p>10. Price for services should be developed with input from several variables</p> <ul style="list-style-type: none"> a. True cost to deliver the service (direct costs) b. Market rate for the service c. Value of the service to the payer d. Market demand for said services e. Access to proposed services in the market f. Indirect rate required to deliver said services 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<p>11. Develop prices for services using input from several variables: price, capacity and legal structure to deliver said services</p>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Phases and Steps	Achieved and ready to share lessons learned with others	Making progress but not ready to share	Just beginning and may need help	Haven't started yet; Definitely need help	Additional Notes
Phase II: Engagement					
1. Forge relationships and partnerships in the marketplace with potential allies a. Educate allies about your menu of services b. Educate allies about steps taken to initiate culture change c. Educate allies about the menu of services, capacity to deliver services, and pricing structure d. Educate allies about the new legal structure (if applicable)	□	□	□	□	
2. Present your menu of services and price to potential payers a. Identify value proposition to the payer for your services b. Value proposition should include total value of services to the payer c. Highlight the role of said services to meeting the quality requirements that the payer must adhere to d. Detail how quality of services will be tracked, monitored, and reported to payer e. Present legal structure for contracting for services f. Present desired contract vehicle required to deliver services	□	□	□	□	
3. Present your menu of services and value of said services to potential consumers	□	□	□	□	

Phases and Steps	Achieved and ready to share lessons learned with others	Making progress but not ready to share	Just beginning and may need help	Haven't started yet; Definitely need help	Additional Notes
Phase III: Post-Engagement					
1. Perform Continuous Quality Improvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
2. Assess organizational capacity to meet demands of marketplace and develop plan for expansion into new areas, building staff, scalability of services to meet growing demand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
3. Continue to perform marketing to potential and consumers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
4. Perform periodic review of service costs and pricing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
5. Continue to assess market drivers in the marketplace a. Regulatory requirements b. Political factors c. Contractual requirements d. Consumer demand e. Changes in payer base f. Changes in consumer base	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6. Stay vigilant for new potential threats in the marketplace a. Take steps to address threats when identified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
7. Stay vigilant for new opportunities in the marketplace a. Take steps to take advantage of new potential opportunities in the marketplace (ie subscribe to listservs, monitor regulations/rules, regularly attend industry conferences)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Summary Sheet for ACL Business Acumen Contracting Life Cycle Self-Assessment				
	Already Achieved	Making Progress	Just Beginning	Haven't Started
Phase I: Pre-Engagement				
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phase II: Engagement				
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phase II: Post-Engagement				
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>