# Contract Compliance Crosswalk

When it comes to contract evaluation, compliance, and anything touching on risk management and operations, it is important to start with the relevant disclaimers. First, the purpose of this tool is to identify ***some*** of the contract terms which PSH organizations should be aware of when preparing to implement PSH and FCS programs through Medicaid. This tool is not comprehensive, does not provide legal advice, and cannot replace individual evaluation and consultation with legal and compliance professionals. In creating this limited (illustrative) walkthrough or example, Atrómitos referenced the standard Amerigroup Participating Provider Agreement for the Foundational Community Supports (FCS) Program provided in March 2023 and last updated in May 2020.

What this tool ***does*** is provide a process and template that an organization can use to ensure that it has (1) identified relevant contract terms that impact operations and (2) a plan for how to address gaps in capacity and operations.

## A Closer Operational Review

**Toolkit #8 (Foundational Community Supports (FCS) Contract Evaluation)** outlined how to evaluate the FCS Contract to determine whether it aligns with an organization's strategic plan, current capacity, and operations in order to make a "go-no-go" recommendation to leadership. Once an organization determines to pursue FCS contracts or has contracted to be an FCS provider, the next level of review needed is more granular.

The purpose of this review is not just to determine if this is a good or feasible opportunity; instead, the focus is on implementation. This means that the focus turns from "can we do this" or "should we do this" to "how will we do this" and "what other resources (people, processes, systems, and time) do we need in order to meet this requirement."

### THE PROCESS

For this reason, an individual or a Compliance Work Group (including and ideally led by either the Compliance Officer or the team member responsible for the implementation of FCS services) must go through the contract line by line to ensure that all contract requirements (regulatory, programmatic, and those directly related to services delivery) are fully identified and understood.

This can be done by a single individual, such as the team member responsible for PSH services, with the support of team members from across the organization tasked with reviewing and providing feedback within their specific domains.

Alternatively, this work can be completed through a Work Group, where the individuals whose feedback is needed are integrated upfront into the contract review planning and evaluation process.

**As described in Toolkit 8, a project plan should be developed defining:**

1. The parameters of the review (what are the questions that need to be resolved);
2. The timeline, associated tasks, and assigned responsibilities;
3. The process by which gaps in current capacity will be identified and prioritized;
4. The resources available to address gaps in compliance or capacity (in both the immediate and longer terms)
5. The process by which feedback will be collected and how it will be presented to decision-makers for action.

An operational review of a contract is intensive, comprehensive, and iterative. What is important is that the terms of the contract are **thoroughly** understood by the organization. This means identifying those areas where additional resources and capacity development are needed. There will likely be areas of operations where an organization does not have existing procedures and resources allocated. For example, suppose an organization has never contracted as a healthcare provider or business associate.

In that case, it may not have HIPAA Privacy and Security Policies and Procedures, or, if the organization has not previously contracted with the State, its document retention policy may not align with those standards. This is to be expected. What is important is that the full scope of contract requirements are identified and understood and that there is a plan and pathway to meet those terms, to evaluate and monitor performance on contract terms within the organization (including compliance requirements), and to continuously improve over time.

This means, first of all, that **there are no shortcuts when it comes to contract review and evaluation.** The contract has to be gone through line by line—and then also cross-referenced and evaluated against those documents that are incorporated into the agreement (such as the Provider Manual and the Business Associate Agreement).

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**The following are some practical recommendations when conducting this contract review:**

- Print out the Contract in order and mark it up with notes, highlighting areas, and raising questions.
- Familiarizing with the structure and "flow" of the contract. Think about how it is organized. How are sections categorized to recognize the 'logic' of its structure. Being comfortable with the document's structure is also important, as terms in the contract cross-reference with other sections.
- After completing a "first" review and mark-up, return to the contract and paraphrase each section in layman's terms. This exercise, explaining the content of each section in simpler terms, helps to ensure that the reviewer actually understands a section – and to identify where there are potential ambiguities or unanswered questions.
- Paraphrasing each section can also help the review of other team members ("subject matter experts" working in specific areas of operations) in their review, as well as helping to think through WHO in the organization is needed to provide feedback (i.e., who will have an answer to the question raised?).
- Use a contract crosswalk to organize and document the operational evaluation. A proposed contract compliance crosswalk template is provided in this Toolkit.

## ANATOMY OF THE FCS CONTRACT

Before turning to the proposed crosswalk template, it is helpful to "get comfortable" with the Contract as a ***document***, that means thinking of it in the context of its structure and objectives. This is one of those times in life when an English major comes in handy.

There are ten (10) sections or Articles to the Contract, as well as one (1) Appendix and one (1) Attachment. In addition to the 41-page document, other documents that are incorporated by reference and impact the application of the agreement include:

1. The HIPAA Business Associate Agreement with Amerigroup;
2. Amerigroup's Provider Manual; and
3. Amerigroup's Policies and Providers govern providers and the FCS Program's administration.

### Article I: Definitions

This includes a list of the defined terms that are used throughout the contract. Definitions tend to be statutorily or regulatorily directed.

### Article II: Amerigroup Obligations

This section outlines Amerigroup's obligations to the participating provider. Generally speaking, this includes the responsibility to (1) publish and make available a Provider Manual detailing the policies and procedures governing provider operations; (2) to provide Reports to Provider as required by regulatory Requirements (i.e., as required by the Medicaid agency); (3) conduct credentialing for the program; (4) furnish Provider with schedules of Covered Services and provide timely notice of any modifications.

While short, this can still be an impactful section to review, not least as there can include terms limiting the scope or extent of an obligation or imposing a responsibility on a provider. As one example, this section details that Amerigroup must make the Provider Manual available to Provider and reference "material policies and procedures" in the Provider Manual (Section 2.2: Policies and Procedures) and to give notice of material modification to policies and procedures to Provider. However, this section ***also*** requires Providers to comply with all policies and procedures communicated to providers (including policies and procedures not included in the Provider Manual).

### Article III: Provider Obligations

This is a denser section and is one of the areas requiring the closest review operationally. This includes a general statement of provider services (Section 3.1) and the responsibility to operate within all licensure and accreditation requirements, minimum standards of insurance (Section 3.8), and the identification of proprietary information between the parties and duty to maintain confidentiality (Section 3.10).

The Provider Manual and Policies and Procedures are ***most*** important to the evaluation in this section. Consider Section 3.7 (Compliance with Credentialing, Utilization Management, Quality Assurance, Grievance, Coordination of Benefits, Third Party Liability and other Rules, Regulations, Policies and Procedures). By contract, a provider is subject to these programs and requirements. Review of the Provider Contract, which summarizes the relevant programs and primary responsibilities, is critical to understanding how this will actually operate in practice.

### Article IV (Reimbursement)

This is a shorter section governing the terms by which providers must document and bill for services and by which Amerigroup will process those claims. This section does not provide the rate of reimbursement (which is detailed in Attachment A). Be mindful of the policies and procedures governing claims processing in the Provider Manual in order to better understand how claim submissions, reviews, appeals, and recoupments operate in practice.

### Article V (HIPAA)

This section references regulatory compliance with HIPAA. Be mindful that there is a positive duty for a provider to execute a Business Associate Agreement with the Administrator (Amerigroup) where the provider is not a "covered entity" under HIPAA (i.e,: a healthcare provider)

### Article VI (Compliance with Regulatory Requirements)

This section details the FCS program's regulatory requirements and under which the Administrator and all contractors must operate. Section 6.1 (Compliance with Regulatory Requirements) functions as a "catch-all" by which a provider agrees to comply with all regulatory requirements, regardless of whether they are expressly referenced in this section. This section then proceeds to give a detailed run through of the relevant operational requirements and prohibited practices. This section is integral to identifying, developing, refining, and 'testing' the scope and substance of an organization's compliance program.

### Article VII (Records)

Providers have a duty to create and retain adequate records related to the delivery of services. Those records must be maintained in a secure and confidential manner. Records are subject to audit by Amerigroup following reasonable notice. Providers have the duty to cooperate in the timely transfer of records to other Providers, as required.

### Article VIII (Complaint/Dispute Resolution)

This outlines the procedures associated with resolving disputes between Amerigroup and a provider.

### Article IX (Term; Termination)

This section outlines the term of the agreement (2 years), its default renewal, and the process for termination by either party.

### Article X (Miscellaneous)

While "miscellaneous" suggests a section that is a catchall of those terms that don't fit elsewhere in the agreement's structure, it still contains important terms that merit attention. This includes the terms which Amerigroup may amend the agreement, by which parties must provide notice, and indemnification.

The above is a brief snapshot of the "architecture" of the Agreement itself, but some of the most important terms are actually contained in the attachments.

### Appendix A (Foundational Community Supports Program)

This is the most important section as it relates specifically to the FCS program requirements and service delivery. This defines the FCS program, criteria, provider qualifications, and the specific capacity requirements relevant to the program.

Close attention to Sections 2a (Adherence to Quality Standards Supportive Housing), 3 (Administrative Requirements), and 4 (Reports, Monitoring, Quality Standards and Deliverables) are critical to understanding operational requirements and impact.

### Attachment A (Medicaid Reimbursement)

This details the Reimbursement rates and includes specific directions on the process of submitting claims ( i.e., use of CMS 1500 form and Availity).

## Putting Pen to Paper: The Proposed Contract Crosswalk

With that background in contract structure, and once each reviewer completes a hard copy (and marked up) review, the Project Lead should collect feedback in an operational contract crosswalk. This means that reviewers identify each section that has a significant operational impact, providing a citation (Section Column); a paraphrased description of the application (Description Column); an explanation for why it raises a concern or why there is a gap in current operations (Point(s) of Concern column); assign a level of priority (Priority Level); and detail how that gap can be addressed (Recommendations column).

For example, one entry under Article III (Provider Obligations) might reference Section 3.8 (Insurance Coverage), which stipulates that all (non-acute hospital) providers must maintain professional liability coverage with a minimum coverage of $1 million dollars per occurrence with coverage for $3 million in the aggregate.

A reviewer for an organization that didn't meet this minimum coverage level would identify this gap—give it a high priority level (signaling immediate action because the organization is out of compliance with the term) and describe the steps being taken (or that need to be taken to address this), such as "Alerted CEO and Legal of need to raise insurance coverage immediately. Legal has contacted Insurance company. Resolution expected within 3 days").

A snapshot of the beginning of such a Contract Crosswalk is provided in the table below. This table is provided for illustrative purposes to demonstrate how team members may develop the crosswalk.

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**TABLE 1.** FCS CONTRACT CROSSWALK – A SNAPSHOT

| Section | Description | Point(s) of Concern | Priority Level | Recommendations |
|---|---|---|---|---|
| **Article I (Definitions)** | This includes a list of the defined terms that are used throughout the contract. | | | |
| ***1.3 Clean Claim*** | Defined as claim that can be processed without additional documentation | No concern on definition. Flagging for reference to Billing team. | Low | Include in training for Billing team. Likely will be useful to reference for denied claims in reconsideration/reprocessing. |
| **Article II (Amerigroup Obligations)** | Summarizes Amerigroup's duties to providers. Includes duty to publish provider manual and share quality reports as directed by HCA. | | | |
| ***2.1 Provider Manual*** | Duty to publish manual and make available to providers. Provider is subject to terms of Provider manual. Amerigroup must provide 60 days notice of any material changes to provider manual. | Need to confirm how notice will be made ( i.e., formal notice through procedures in contract or through mass notification through provider newsletter). Need to review Provider Manual to determine acceptability of P&P imposed. | Medium | Provider Manual being review by PSH service director. Assign member of billing team to monitor monthly newsletters to identify notice of any changes. Develop procedure for evaluating modifications to manual to determine if additional review by management is needed. |