Home & Community-Based Services

Brokerage Design Guide

A road map for establishing a brokerage for home and community-based services

County of San Diego
Health & Human Services Agency
Aging & Independence Services

August 2014

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY
Aging & Independence Services

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Development of a home and community-based services brokerage supports Live Well San Diego, an innovative initiative of the County of San Diego to be Healthy, Safe and Thriving.

Acknowledgements

This guide was prepared by the County of San Diego Health & Human Services Agency, Aging & Independence Services, in partnership with Collaborative Consulting and the Home and Community-Based Services Design Team, which was convened for this project. The Design Team was comprised of local thought leaders representing healthcare providers, healthcare payors, and home and community-based services (HCBS) providers.

Aging & Independence Services adapted innovation concepts for this project from *Discovery-Driven Growth: A Breakthrough Process to Reduce Risk and Seize Opportunity* (2009), Rita Gunther McGrath and Ian C. MacMillan, Harvard Business Press.

The project was supported by a grant from The SCAN Foundation - advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit www.TheSCANFoundation.org.

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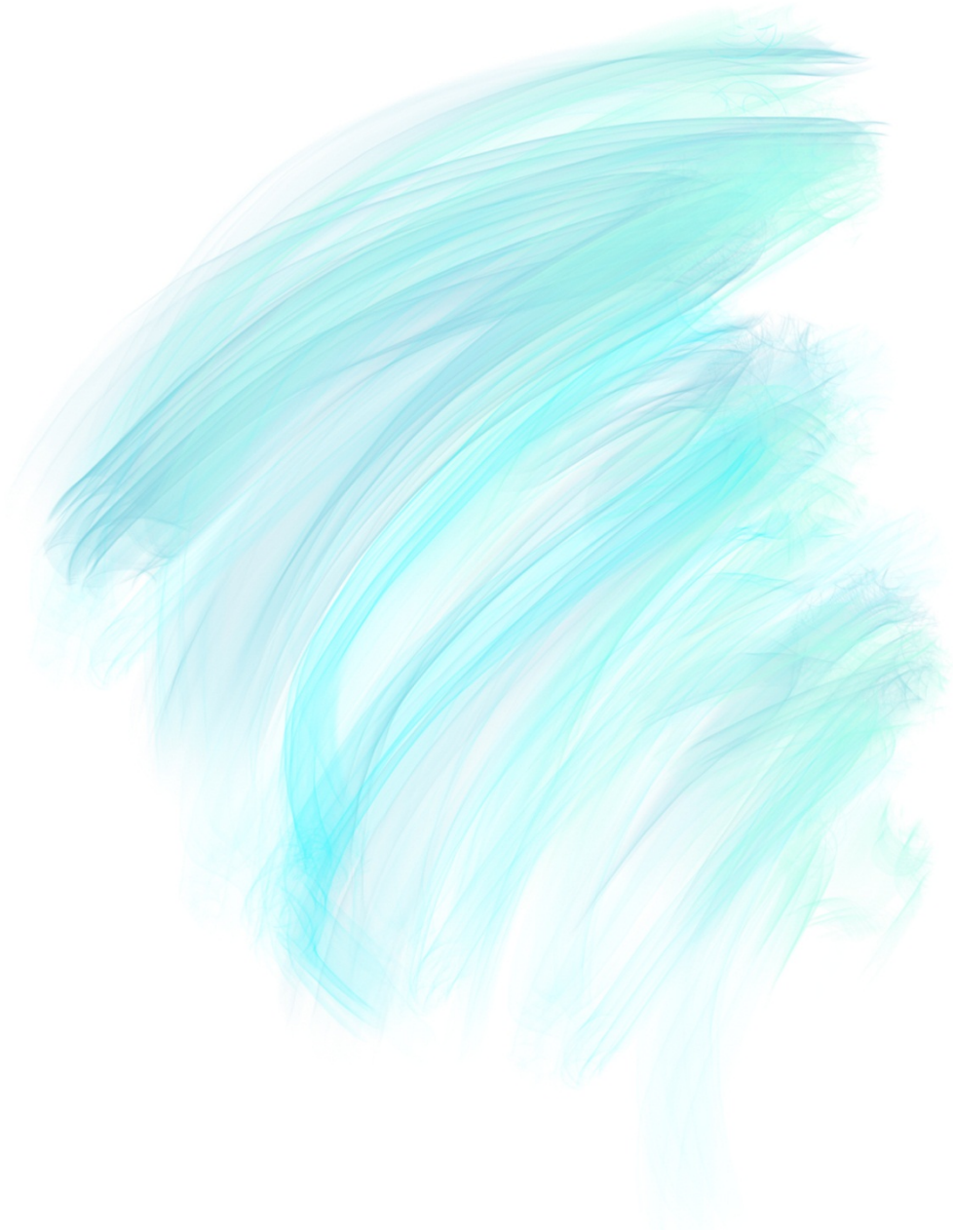


The Need

For years, healthcare and social supports have operated as two very distinct systems of care, with each conducting an assessment and establishing a plan of care. This often results in uncoordinated care that is riddled with both gaps and duplications in services for a consumer of both health care and social service. These two systems of care, which speak different languages and have very different cultures, financing structures, and priorities, are challenged to coordinate care. As a result, older adults and persons with disabilities are subjected to a fragmented service delivery system that is difficult at best to impossible for them to navigate. This fragmented system of care does not prioritize the individual's needs or preferences, and it often results in poor health outcomes and escalating healthcare costs.

Changes in the healthcare environment, initiated through such programs as the Coordinated Care Initiative (CCI) in California and the Community-based Care Transitions Program (CCTP), have highlighted the need for community-based supportive services to help medically complex individuals to live as independently as possible in their own homes and communities. However, healthcare organizations often find it challenging to keep abreast of the wide array of community-based support expertise and services that these individuals typically require. A single resource for healthcare organizations to secure community-based support services for these individuals will better coordinate the two systems and result in improved healthcare outcomes.

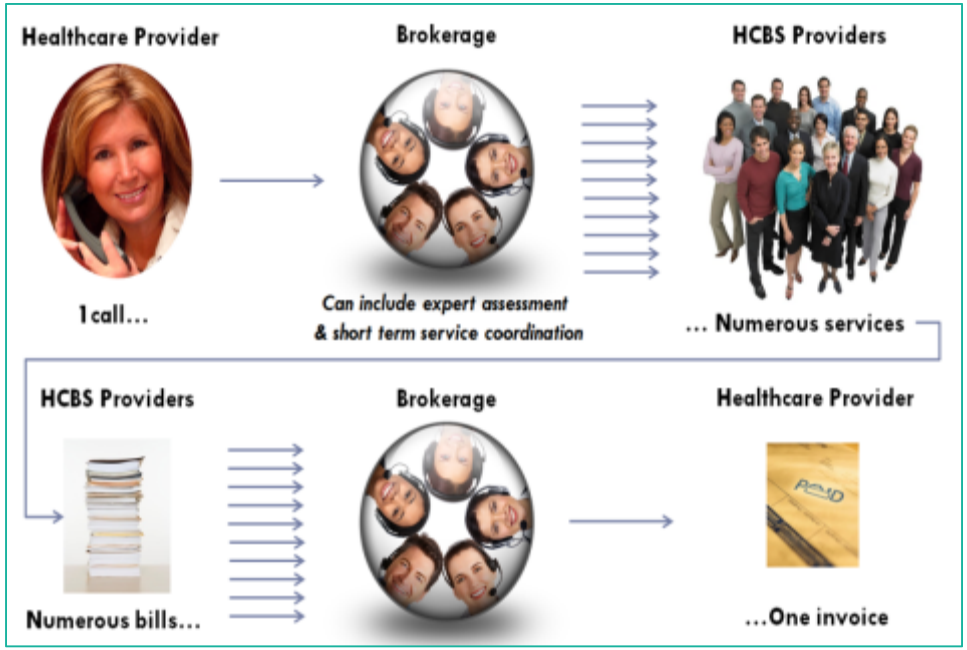
An Opportunity

Establishing a community-based brokerage could provide access to a network of quality home and community-based services (HCBS) that support individuals to receive the right services, at the right time, in the setting of their choice. As a single referral entity for individuals with complex needs, a brokerage would help to reduce or eliminate duplications and gaps and increase utilization of HCBS, which have been demonstrated to:

- Reduce overall per patient healthcare costs;
- Reduce emergency room utilization;
- Reduce hospitalizations and readmissions;
- Reduce out of home placements and;
- Improve HEDIS measures for populations served.

If implemented, a brokerage established by a lead entity would afford easy access to a variety of HCBS for interested healthcare payors, providers, individuals and caregivers. It would also afford an additional resource for HCBS providers to serve individuals with medically and socially complex needs. The brokerage would also work to ensure that an adequate provider network exists to support the rapidly growing aging and disabled population in a community.

Figure 1 – One example of an HCBS model



Design Guide

Purpose, Scope and Format

This guide provides a framework to analyze the feasibility and potential demand for a local brokerage as well as recommended actions for implementation. As each community has many variables, this guide is not intended to be prescriptive. Its purpose is to outline potential models and to provide considerations for the development and implementation of a home and community-based services brokerage. It is by no means exhaustive of all possibilities: therefore, organizations pursing such an opportunity should secure business and legal counsel.

A case study with components of the process undertaken by the County of San Diego is included with the guidelines to illustrate the concepts of the guide.

Design Overview

The outline below provides a high level synopsis of steps to consider before implementing a home and community-based services (HCBS) brokerage. It is not necessarily sequential, and many of the steps may be performed concurrently. Each step is explored in more detail in the following sections.

Step 1: Design the Service Model

Lay the foundation by identifying the need, beginning to develop the business case, and designing the service delivery model.

Existing state

Identify the needs and current issues in your community related to accessing HCBS.

Unit of service

Identify potential units upon which charges might be based (such as per referral or per hour) and select a unit to use. Do this early in your exploration as it may influence the service delivery model.

Customer experience

Design and map one or more potential service delivery models.

Value added

Identify the value added or subtracted for each proposed service model, and select a model to pursue.

Unknowns

Begin to document areas of uncertainty that need further exploration.

Design Overview

Step 2: Identify the Requirements

For each step in the service delivery process, consider the requirements and capabilities of the following components in light of the proposed service model and document uncertainties.

- Workspace and infrastructure
- Workforce
- Technology
- Finance
- Billing
- Audit and compliance
- Legal and contracting
- Risk management

Design Overview

Step 3: Assess Viability

Determine the viability of the proposed service model by conducting the following:

- Market analysis
- Environmental scan
- Financial viability assessment

Step 4: Select the Business Model

Determine the legal structure of the brokerage business entity.

Design Overview

Step 5: Resolve Unknowns

Develop a plan and timeline for resolving uncertainties, including identifying issues that would indicate the brokerage would not be advisable as designed.

Step 6: Implement!

Prepare for a successful implementation by designing the following:

- Marketing strategy
- Implementation strategy

The Case Study

Current Service Model: The Local ADRC

In the case study, the local Area Agency on Aging (AAA), the County of San Diego's Aging & Independence Services (AIS), is the lead agency in the county's Aging & Disability Resource Connection (ADRC). The ADRC is a shared, core partnership between AIS and Access to Independence, the local Independent Living Center (ILC). The ADRC performs four functions: provides information and assistance about long term service and support (LTSS) options; offers options counseling to assist individuals to identify LTSS that meet their needs and preferences so they can create an individualized plan of care; delivers short term service coordination for individuals who meet specific eligibility for services; and supports patients who are discharged from the hospital and are at risk for a readmission. The addition of a brokerage to ADRC core services would both expand capacity and streamline access to HCBS even beyond the current ADRC network of partners by establishing a single entity that is accountable for contracting and billing for both utilizers of the brokerage and HCBS providers.

Nationwide, AAAs (government and non-profit) are uniquely positioned to engage a variety of partners to operate an HCBS brokerage due to their relationships with local organizations providing home and community-based services. Many are already contracting with these HCBS providers for the delivery of Older Americans Act (OAA) services. Some, such as San Diego County's AAA, also have long-standing relationships with healthcare payors and providers.

Early Analysis

As a first step to addressing this need, key AIS staff with subject matter expertise completed some ground work and drafted potential service models for a brokerage operated by the ADRC. Preliminary analysis identified two potential service delivery models. The first model focused on providing only referrals to HCBS. The second built upon the first by adding an assessment and short term service coordination. Both models appeared to add significant value, providing a single resource for healthcare providers to access multiple HCBS for their patients and to receive a single monthly invoice though the ADRC.

The analysis included the following:

Step 1. Model Design & Assessment

To lay the foundation, the AIS core team looked at:

- **Existing state:** Identified needs and issues
- **Unit of service:** Identified potential units upon which charges might be based
- **Customer experience:** Designed and mapped the service delivery process for each of the proposed models: A) referral only, and B) assessment and short term service coordination
- **Value added:** Identified the value added or subtracted for each proposed model
- **Unknowns:** Document uncertainties

Step 2. Start Up Requirement Identification

In a series of meetings that were grouped by disciplines (including information technology, healthcare provider and brokerage, facilities, fiscal and contracts, and HCBS contracted services) key subject expert staff:

- Provided input into service model process maps
- Determined what needs to be in place if an ADRC were to operate the brokerage via contractor services
- Documented uncertainties

Step 3. Prioritization for Resolving Unknowns

The AIS core team reviewed the list of unknowns and developed a preliminary timeline for resolving them.

The HCBS Brokerage Design Team

Upon completion of the early analysis by the AAA/ADRC, a contract with Collaborative Consulting was executed to provide meeting facilitation and research on potential and existing brokerage business models. Key thought leaders from the local healthcare and home and community-based services communities were selected to participate on an HCBS Brokerage Design Team to further develop the model. The team, often referred to as the Dream Team, was comprised of executive level experts that represented the target stakeholders that would either purchase or provide services through a brokerage. Key findings from the early analysis formed the starting point for the HCBS Brokerage Design Team work. Members of the Design Team shared their insights and those of colleagues within their organizations via pre-meeting surveys and in two in-person working meetings. They presented initial perceptions about support, concerns, and barriers to implementing a brokerage locally. The team also identified similar solutions under development and the anticipated response to those solutions. They provided feedback on the preliminary work and content for this guide. Finally, the team identified the various types of HCBS needed by older adults and persons with disabilities[1] and shared their assessment of the local community's capacity to meet the demand for these services. The results revealed that as a community, the San Diego region does not yet have a solid understanding of whether there is sufficient capacity to meet the potential demand. A formal needs assessment and gap analysis is currently underway.

The early analysis, which provided the foundation for the project and the work of the Design Team, resulted in a step-by-step roadmap that could be utilized by other communities. This will be valuable for entities contemplating how to improve access to HCBS for healthcare providers and payors, especially for those who are being held accountable for improving the quality of care while reducing costs for medically complex individuals. The step-by-step roadmap is detailed in the sections that follow. Additionally, the San Diego County Case Study tables (***Appendix B: Case Study Tables***) provide further insight into the type of analysis that is recommended to establish an HCBS brokerage.

[1] See ***Table 18*** in *Appendix B: Case Study Tables*

Step 1: Design the Service Model

The Existing State

Before designing a brokerage model, it is essential to identify potential customers, understand their needs, and assess factors in the environment that may have a bearing on success. Potential customers might include persons ready for discharge from a hospital or care facility as well those currently residing at home who have need for community-based support services. What is not working? What are the current gaps? How are people currently getting their needs met? ***Tables 2-4*** in *Appendix B: Case Study Tables* demonstrate this process and include content from the assessment in San Diego County.

The Unit of Service

Consider various methods of billing for services. Don't limit this to existing models, but also explore creative means for charging for services. It is important to do this early in the process as the billing unit may impact how service is delivered and also provide a new opportunity for innovation. Potential methods of service are included in ***Table 5*** in *Appendix B: Case Study Tables*.

The Customer Experience - Service Delivery

Once the existing state and unit of service have been determined, the next step is to design the service delivery model. Begin by brainstorming how the healthcare providers' and payors' needs may be better addressed. Consider the challenges they are currently facing in accessing HCBS. Also consider factors in the current environment upon which to capitalize to provide a solution. For example, are there potential partners whose expertise might be leveraged? What are the motivators of potential partners? Is there a trusted entity that has the capacity and interest to function as the lead entity? Are there funding streams that might be utilized? Design the service delivery model around these factors.

In the case study, San Diego County designed two models. In the first, the brokerage functioned simply as a hub for referrals linking healthcare providers and payors with needed HCBS. In the second, assessment and short term service coordination activities were added. Below is a high level summary of these two service delivery models.

Model A: Referral Only

- Healthcare provider/payor requests services
- Brokerage secures requestor's agreement with selection of HCBS provider
- Brokerage arranges for HCBS
- Brokerage confirms that services were delivered
- HBCS submits invoice for payment to brokerage
- Brokerage pays HCBS provider
- Brokerage sends invoice monthly to healthcare provider/payor for all services rendered to their members/patients

Model B: Assessment and Short Term Service Coordination

In addition to the steps in Model A, Model B includes the following:

- Brokerage completes a needs assessment
- Brokerage performs short term service coordination (defined as 30 days)

Figures 2-3 in *Appendix B: Case Study Tables* includes a high level process map for each of these models.

The Value Added - The Early Business Case

Overall Value

Once one or more models have been designed, compare the value of each against the current state as well as against one another. ***Table 6*** in *Appendix B: Case Study Tables* details this step and includes results from the San Diego County case study.

The analysis focused on four aspects of service delivery (speed, cost of services, availability and quality) and compared the potential value of the two proposed models and the current state, *relative to one another*. As there were many variables, those that were similar among the three options (existing state, Model A and Model B) were not listed. For each aspect considered, a determination was also made regarding whether a brokerage would be duplicative of current resources or would provide more or less value than the existing state. At this point, few specifics were known, so the goal was a high level comparison to determine whether these models appeared worthwhile to pursue.

In the case study, the results indicated that both brokerage models would provide significant value over the current state, with Model B: Assessment & Short Term Service Coordination providing the greatest added value.

Customer Experience

Next, examine the brokerage utilizer's experience throughout the entire service cycle, beginning with the initial awareness of the service and progressing through completion of the service relationship. In the San Diego County case study, the brokerage utilizer was the healthcare provider/payor. The analysis examined awareness of the service, access to the service, use of the service, payment and discontinuance of the service relationship.

Table 7 in *Appendix B: Case Study Tables* shows the case study comparison for the two proposed brokerage models and the existing state, *relative to one another*. As stated before, variables that were consistent among the three options were not listed. Since this was still very early in the analysis process and few details were known, the goal was to complete a high level comparison to assess the value to the healthcare provider/payor and to provide insight into whether these brokerage models should be pursued.

Here, too, both proposed models added substantial value over the existing state; however, when examining the models from this viewpoint, Model B provided no greater value than Model A.

Key Performance Metrics

It is also important early on to assess how the models would be expected to impact key performance metrics. ***Table 8*** in *Appendix B: Case Study Tables* compared the *anticipated* performance of each of the brokerage models and the existing state, *relative to one another,* in core areas that are important to the brokerage user. The performance metrics evaluated included:

- Reduction in per patient healthcare costs overall
- Reduction in ER utilization
- Reduction in hospitalizations and readmissions
- Reduction in out of home placements
- Improved HEDIS measures for the target population

The rankings of high, medium and low were used to signify the level of impact each model would be projected to have on improving the respective metric. The results reflected the anticipated outcome of increased utilization of HCBS through the use of the brokerage. ***Table 9*** in *Appendix B: Case Study Tables* also identified additional metrics important to the customer that a brokerage might want to track.

Should a brokerage be developed, it will be important to determine the performance metrics and as well as the corresponding results that will demonstrate value both to brokerage utilizers and to service providers.

Summary Value Assessment

A final step in determining whether a brokerage might provide significant value is to step back and consider the overall impact in light of the above assessments. Does the proposed model promise significantly more value over the existing state, enough so that potential users will be enthusiastic about it? Could it possibly even change how value is measured? ***Table 10*** in *Appendix B: Case Study Tables* shows the overall value of the case study's potential service models.

Unknowns

Begin to record uncertainties that arise as you work through this process. Continue to document these unknowns throughout the following steps.

Step 2: Identify the Requirements

Start Up Requirements

For each step in the service delivery process, identify what needs to be in place to start up and to operate the brokerage. Consider workspace and infrastructure, workforce, technology, finance, billing, contracting, legal, audit, compliance, and marketing needs. A sample worksheet is provided in ***Table 11*** in *Appendix B: Case Study Tables*.

The sections that follow provide additional considerations for many of these needs. ***Tables 12-15*** in *Appendix B: Case Study Tables* dive deeper into each category.

Workforce

There are many considerations when determining workforce needs for a brokerage. For example, who will staff the brokerage (in-house or other)? What are the required skill sets and educational requirements for brokerage staff? It is also important to consider strategies for flexible staffing to meet fluctuating workload demands. See ***Table 12*** in *Appendix B: Case Study Tables* for examples.

Audit & Compliance

Audit and compliance needs should be determined prior to establishing a brokerage. ***Table 13*** in *Appendix B: Case Study Tables* includes considerations for documentation and reporting as well as standards and regulations that may apply. Legal counsel should be obtained to ensure compliance with federal, state and local regulations.

Legal & Contracting

There are several considerations regarding legal and contracting matters when creating a brokerage model. Key topics to be addressed include liability, documentation, insurance, data sharing, confidentiality, accountability, and regulatory oversight. If

the brokerage contracts with the HCBS providers or assumes responsibility for provider service quality, vetting service providers will be critical to the success. Vetting factors should be developed and documented fully in the agreement. ***Table 14*** in *Appendix B: Case Study Tables* lists some considerations but is not intended to be comprehensive, as business structures and needs vary. Therefore, organizations considering implementing or participating in a brokerage should consult legal counsel.

Risk Management

Before creating or joining a brokerage, it is important to identify and mitigate potential risks. Consider challenges in areas such as capacity, quality, legal, liability, financial and service provision oversight. ***Table 15*** in *Appendix B: Case Study Tables* details risks and mitigations identified by the San Diego County case study. When managing risk, some risks will be deemed acceptable because they will be low impact or unlikely to occur. Others will be deemed acceptable because if they occur, the impact will be manageable. Those risks with greater impact that are likely to occur will need to be addressed.

Case Study: Top Three Challenges & Potential Solutions

In the San Diego County case study, the top three challenges and potential solutions were identified.

Table 1 - Case Study: Top 3 Challenges & Potential Solutions

Challenges	Potential Solutions

Ensure return on investment (ROI)	• Secure professional assistance in developing a financing/budget model
	• Consider initial funding from sources such as:
	  o Grants
	  o Charities/foundations
	  o Social impact bonds
	• Demonstrate additional ROI via:
	  o Increased customer satisfaction scores
	  o Increased patient retention
	  o Improved HCAHPS scores
	  o Decreased administrative costs

Understand the need for HCBS services and the community capacity to meet the needs	Conduct an analysis of client needs and community capacity to meet them
Secure real time, bi-directional data management technology	Consider accessing a regional Healthcare Information Exchange (HIE)

Unknowns

Continue to document areas of uncertainty throughout step two.

Step 3: Assess Viability

Market Analysis of Community Readiness

Before pursing implementation of an HCBS brokerage, an analysis should be conducted locally to determine the following:

- potential usage for HCBS,
- the level of interest of healthcare providers and payors, and
- the capacity of HCBS providers to meet the projected need.

For example, in the case study, San Diego County is in the process of determining the potential usage and capacity of a brokerage. To determine potential usage, the U.S. Census American Community Survey (2008-12 5yr estimates, Table S1810) will be used. This data includes the total population with a disability and breaks out the data by those with a hearing, vision, cognitive, ambulatory, self-care, or independent living difficulty. To determine the community capacity to meet the potential need, San Diego County will be overlaying the U.S. Census Survey data with local HCBS provider capacity data. GIS mapping will be used to support analysis.

Environmental Scan of Current Solutions

Conferring with organizations that are currently operating or participating in a similar brokerage model can provide valuable insight into what works well, potential challenges and methods to overcome them, and mistakes that might be avoided. The information below details the findings of the environmental scan performed by Collaborative Consulting for the case study in San Diego County.

[2]The following organizations are pursuing and/or are involved in some form of network model/arrangement, and should be explored in more detail by any organization that is considering the development of and/or participation in a network/brokerage-like model.

1) Direction Home - Ohio Area Agencies on Aging (AAA)
2) Coordinated Care Alliance, Illinois
3) San Francisco Network of Aging and Disability Community-Based Organizations

1) Direction Home Ohio

Direction Home's network of Area Agencies on Aging (AAAs) promotes independent living for older adults and people with disabilities. This is a cooperative of in-home and care transition specialists, rooted in communities throughout Ohio. Healthcare providers and Managed Care Organizations (MCOs) can rely on the network for quality in-home care solutions that dramatically lower costs.

Legal structure:	LLC
Tax status:	For benefit, for profit
Owned by:	12 AAAs, each of which are members (owners) of the LLC
Board:	CEO of each AAA

[2] This section was prepared by Collaborative Consulting, Inc. Sources include interviews with community-based organizations, discussion with Administration for Community Living (ACL) technical assistance providers, review of websites, and review of materials from a workshop conducted by The SCAN Foundation's Business Acumen Strategy Meeting, including the PowerPoint.

2) Coordinated Care Alliance

The Coordinated Care Alliance (CCA) is a not-for-profit membership organization combining the expertise of Care Coordination Units (CCU) throughout Illinois. The CCA members focus on strengthening quality, reducing cost, and assisting clients to remain independent for as long as possible. The network of 25 members contracts with MCOs and Accountable Care Organizations (ACOs) to provide services such as assessment, case management, transitional care, and outcome reporting.

Legal structure:	Corporation
Tax status:	Tax exempt 501(c) (3), not for profit
Owned by:	No ownership
Board:	A representative from each member organization

3) San Francisco Network of Aging and Disability Community-Based Organizations

This is a county organization selected by ACL to receive targeted technical assistance to build business capacity and explore the viability of community-based integrated care networks. San Francisco is in the very early stages of the development of their network, but considering forming some structure that represents a Management Service Organization (MSO).

Financial Viability

The completion of the previous tasks of developing a model that adds value, identifying the requirements to operate the brokerage, and conducting a market analysis will provide the information needed to determine the financial viability. Several budgeting and financial planning tools are available on the Internet:

- *The SCAN Foundation Budget and Financial Planning Tool:* http://thescanfoundation.org/community-based-organizations
- *Aging & Disability Resource Connection Service Cost Tool:* http://communitychoices.info/adrc/toolbox.html

Unknowns

Continue to document areas of uncertainty throughout step three.

Step 4: Select the Business Model

Potential Business Structures[3]

Key considerations when embarking upon launching a new business (e.g. the brokerage) include ownership, funding, risk, cash flow, non-disclosure, competition, and governance to name a few. Through the conversations that Collaborative Consulting conducted with other entities pursuing brokerage-like businesses, it was discovered that there was confusion around what differentiated legal entities, tax status and organization/business structures. In an attempt to clarify this, the following definitions have been provided:

1. Legal Entities

In starting a business, the type of business entity must be determined. The form of business determines which income tax return to file. The most common forms are partnership, LLC, L3C, corporation, and S corporation. Legal and tax considerations will inform the type of business structure that is chosen. Consideration may also be given to operating an HCBS brokerage through a government entity.

2. Tax Status Exemption

In order for a corporation, LLC or other qualifying entity to receive 501(c) (3) status, it must apply to the IRS for recognition by filing Form 1023, Application for Recognition of Tax Exemption. The application is a comprehensive examination of the organization's structure, governance and programs.

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[3] This section was prepared by Collaborative Consulting, Inc., with input from the County of San Diego. **Sources**: IRS.gov, sba.gov, forbes.com, 501c3.org, interviews with providers.

3. Organizational Structure

An organizational structure is the outline of a company or other entity's framework and guidelines for managing business operations. This structure can exist within both the public and the private sector. In the public sector, government entities can provide the organizational structure upon which to operate a brokerage. In the private sector, there are two primary types of organizational structures: centralized and decentralized. The management services organization (MSO) is an example of a centralized organization structure. It is an entity created to provide management and administrative services to other organizations or to a network or organizations. Services may include billing, technology, quality assurance, contract negation, accounting, etc. In the decentralized structure each entity would manage and administer these operations independently.

Examples of Possible Legal Entities[4]

1. Limited Liability Company (LLC)

LLC is a business structure similar to a sole-proprietorship or a general partnership. It is designed to provide the limited liability features of a corporation and the tax efficiencies and operational flexibility of a partnership. As a pass-through entity, all profits and losses pass through the business to the LLC owners (aka members). Similar to partnerships, the members themselves report the profits/losses on their federal tax returns but not the LLC. Some states, however, do charge the LLC an income tax. What differentiates the LLC is the limit of the liability for which a member is responsible. Typically, the member's investment in the company is that limit. Conversely, a sole proprietor or the partners in a general partnership are each liable for all of the debts of the company.

2. Another type of LLC - L3C

The low-profit, limited liability company, or L3C, is sometimes referred to as a type of hybrid of a nonprofit and for-profit organization. Unlike a standard LLC, the L3C has an explicit primary charitable mission and only a secondary profit concern. But

[4] See ***Table 16*** in *Appendix B: Case Study Tables* for a summary of the differences between LLC and S Corp.

unlike a charity, the L3C is free to distribute the profits to its members/owners. Unlike the traditional LLC, the L3C's articles of organization are required by law to mirror the federal tax standards for program-related investing.

As a form of limited liability company, the L3C offers the same liability protection, flexible ownership and management structure, and pass through tax status as other limited liability companies. In order to qualify as an L3C, the company must be organized and operated to accomplish a charitable or educational purpose, so that production of income or the appreciation of property is not a significant purpose of the company and without seeking to accomplish a political or legislative agenda. These requirements must be stated in the articles of organization of an L3C, and the name of the L3C must contain the words low-profit limited liability company or L3C.

One advantage offered by the L3C is its statutory design to match the requirements of a program related investment (PRI), an investment made by a private foundation (typically taking on the form of a loan, guarantee, or equity) with a socially beneficial purpose that is consistent with and furthers a foundation's mission. Foundations will generally invest in for-profit ventures (outside of a prudent investment portfolio) only if such investments qualify as PRIs. As such, many foundations refrain from investing in for-profit ventures due to the uncertainty of whether such investments would qualify as PRIs, or use costly time and resources to acquire a Private Letter Ruling from the IRS to receive assurance that such investment would qualify as a PRI. L3C proponents assert that the statutory requirements of an L3C minimize this problem by making it easier for foundations to review the LLC operating agreement, which must be carefully vetted for consistency with the PRI requirements.

3. S-Corp

S corporations are corporations that elect to pass corporate income, losses, deductions, and credits through to their shareholders for federal tax purposes. The business is not taxed itself, only the shareholders. Shareholders of S corporations report the flow-through of income and losses on their personal tax returns and are taxed at their individual income tax rates. This allows S corporations to avoid double taxation on the corporate income. S corporations are responsible for tax on certain built-in gains and passive income at the entity level.

An S-Corp is a corporation that has received the Subchapter S designation from the IRS. There is an important caveat: any shareholder who works for the company must pay him or herself reasonable compensation.

Pros and Cons of LLC

One of the features that distinguish the LLC from an S-Corp is its operational ease. There are far fewer forms required for registering and there are fewer start-up costs. Filing taxes is a once-a-year affair on April 15: a single-member LLC files a 1040 and Schedule C like a sole proprietor; partners in an LLC file a 1065 partnership tax return like owners in a traditional partnership.

There are also fewer restrictions on profit sharing within an LLC as members distribute profits as they see fit. Members might contribute different proportions of capital and sweat-equity. Consequently, it's up to them to decide who has earned what percentage of the profits or losses.

LLCs are not the perfect entity for all businesses. First, an LLC has a limited life: when a member dies or undergoes bankruptcy the LLC is dissolved. Typically, you would determine in advance the length of the LLC's duration when you file it with your state. If your plans include taking your company public or issuing shares to your employees, essentially prolonging its life, then you would need to convert to a corporate business structure.

The owner of an LLC is considered to be self-employed and must pay the 15.3% self-employment tax contributions towards Medicare and Social Security. As such, the entire net income of the LLC is subject to this tax.

The IRS also limits the characteristics of the company. An LLC may only have two of the four characteristics that define corporations: Limited liability to the extent of assets, continuity of life, centralization of management, and free transferability of ownership interests.

Pros and Cons of S Corp

One of the best features of the S-Corp is the tax savings. Recall that members of an LLC are subject to employment tax on the entire net income of the business. Conversely, only the wages of the S-Corp shareholder who is an employee are subject to employment tax. The remaining income is paid to the owner as a distribution, which is taxed at a lower rate if at all.

An S-Corp also allows the business to have an independent life separate from the shareholders. If a shareholder dies, leaves the company, or sells his or her shares the S-Corp can continue doing business relatively undisturbed. By maintaining the business as a distinct corporate entity, clearer lines are defined between the shareholders and the business that improve the protection of the shareholders. The tax savings and solidity of the S-Corp also come with a price. As a separate structure, S-Corps require

scheduled director and shareholder meetings, minutes from those meetings, adoption and updates to by-laws, stock transfers and records maintenance.

Tax Exemption - 501 (c) (3)

Section 501(c) (3) is the portion of the US Internal Revenue Code that allows for federal tax exemption of nonprofit organizations, specifically those that are considered public charities, private foundations or private operating foundations. It is regulated and administered by the US Department of Treasury through the Internal Revenue Service. A 501(c) (3) is a foundation organized for a religious, charitable or educational purpose. A tax benefit specific to a 501(c) (3) organization is that any contribution it receives is tax deductible for the donor.

Entities that can seek 501(c) (3) determination from the IRS include corporations, trusts, community chests, LLCs [1], and unincorporated associations. The overwhelming majority of 501(c)(3) organizations are nonprofit corporations.

In order for a corporation or other qualifying entity to receive 501(c) (3) status, it must apply to the IRS for recognition by filing Form 1023, Application for Recognition of Tax Exemption. The application is a thorough examination of the organization's structure, governance and programs.

Difference between 501 (c) (3) and L3C

Taxation

L3Cs are allowed to make profits, which are taxable by the IRS. On the other hand, 501(c) organizations generally are not structured to make a profit, which makes them exempt from taxation.

Fundraising

Nonprofit organizations have a wealth of fundraising options, from foundation and governmental grants to donations. As a for-profit organization, an L3C can raise capital by issuing debt or selling shares. However, its benevolent purpose may make it difficult to attract investment. To make up for this, the L3C was structured to obtain program related investments, or PRIs, from private foundations. With approval from the IRS, nonprofit foundations may invest in businesses through PRIs so long as the

business in some way promotes the foundations charitable purpose. L3Cs are structured to expedite IRS approval for PRIs, and there is a movement to make it so any PRI made to an L3C is automatically approved.

Distributing Assets

Nonprofits are prohibited from distributing its assets to its owners or board members. The proceeds that the nonprofit generates from its activities must be used exclusively for its charitable purpose. In contrast, an L3C is permitted to distribute the proceeds from its activities to its owners.

Adoption of Organizational Form

Since section 501(c) is part of the U.S. Tax Code, any business in the country can apply for that status so long as it meets all requirements. Only nine states allow L3Cs: Illinois, Louisiana, Maine, Michigan, North Carolina, Rhode Island, Utah, Vermont and Wyoming.

Step 5: Resolve Unknowns

Refer to the list of uncertainties that you have been maintaining and identify how and when you will resolve each of them. Identify any that are deal breakers and address these early on whenever possible.

Step 6: Implement!

If, after completing steps 1 through 5, the brokerage appears to be a viable and sustainable endeavor, develop a marketing strategy and establish the implementation plan, steps and timeline.

Marketing Strategy

Marketing is necessary to build the customer base for the brokerage. Identify who needs to know about the brokerage and craft key messages that emphasize the benefits to the respective audiences. Consider all methods of communication such as mail, television, internet, radio and postings at public buildings. Plan media campaigns with strategic and sequenced targeting.

Table 17 in *Appendix B: Case Study Tables* includes the target audiences and key messages from the San Diego County case study.

Implementation Approaches

Once the marketing strategy is complete, refer back to *Step 2: Identify Operational Requirements* and prepare a project plan to build the brokerage. Specify target completion dates for key tasks and deliverables. Include the resolution of any remaining uncertainties as well as activities required to mitigate risks.

Remember, funders will drive implementation.

One of the key challenges will be the "chicken and egg" scenario. To demonstrate value such as cost savings to potential brokerage utilizers (healthcare providers and payors), the brokerage will need

metrics (fall reduction, lower hospital readmission rates, etc.). However, the brokerage will not have this data until it has users. Data may be available from other similar models or from HCBS providers. Data may also be acquired by conducting a pilot. As well as demonstrating value, this would also provide the opportunity to test and refine the model and to confirm viability. The pilot might be short-term, such as six months, and include a single utilizer (healthcare provider or payor). A pilot would allow the brokerage to:

- Test marketing messages
- Test service delivery model
- Collect data
- Collect feedback
- Complete cost and ROI analysis
- Modify processes as needed
- Expand services if useful and viable

Another strategy for implementation might include forming a management structure that engages HCBS and healthcare providers and payors in the design and decision-making process. For example, a Brokerage Steering Committee could create and execute a business plan, outline specific strategies to achieve goals, and use project management techniques to evaluate progress and mitigate setbacks.

Conclusion

An HCBS Brokerage has the potential to make a significant impact on community health and the ability of individuals to maintain their independence. A brokerage would provide a single conduit that unifies the two very distinct systems of healthcare and social supports and affords patient-centered care. By reducing system fragmentation, the brokerage would improve care coordination and eliminate gaps and duplications of services. These outcomes have the potential to lower healthcare costs considerably. A thoughtful analysis and careful planning, including executing a small pilot, can help to ensure successful implementation.

Appendix A

Glossary

Acronym	Meaning	Description
A2i	Access to Independence	Independent living center; core partner in ADRC
ACL	Administration for Community Living	Federal agency tasked to reduce fragmentation of developmental, independent living, health care, behavioral health, and long term services and supports.
ACO	Accountable Care Organization	Formal: Framework created by CMS to provide MSSP-like services to fee for services Medicare clients. Charged to improve outcomes and decrease costs. Informal: Groups of physicians who share risks. Sharp has a pioneer ACO.
ADRC	Aging & Disability Resource Connection	Partnership between Aging & Independence Services, Access to Independence, and Trilogy Integrated Resources, Inc., to provide free information about long term care services and support options to seniors and people with disabilities as well as to their caregivers and service providers.
-	Care Coordination	30 days or less service coordination
-	Case Management	Long term service coordination
CCI	Coordinated Care Initiative	Medi-Cal (Medicaid) care delivery system transformation integrating the administration of medical, behavioral and long-term care services for older adults and persons with disabilities into a single, organized delivery system.
CCTP	Community Base Care Transitions Program	Pilot model for improving care for the transition from the hospital to other settings and for reducing readmissions for high-risk Medicare beneficiaries.
CDA	California Department of Aging	State department tasked with promoting the independence and well-being of older adults and adults with disabilities.
CHHS	California Health & Human Services	State department charged with providing a wide range of health care, social, mental health, alcohol and drug treatment, public health, income assistance, and disabled services.
CMMI	Center for Medicare & Medicaid Innovation	Federal agency that, with CMS, supports the development and testing of innovative health care payment and service delivery models.
CMS	Centers for Medicare & Medicaid Services	Federal agency that provides medical coverage for 100 million people through Medicare, Medicaid, the Children's Health Insurance Program and soon, the Health Insurance Marketplace. Also promotes improved health care at lower costs.
CPT	Current Procedural Terminology	Medical code set maintained by the American Medical Association to communicate uniform information about medical services and procedures.
HCBS	Home and Community-Based Service	Services accessible to families in the least restrictive setting possible.

Acronym	Meaning	Description
	Healthcare Provider	Entity that provides hands-on health care
HEDIS	Healthcare Effectiveness Data and Information Set	A tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service to make it possible to compare the results. Altogether, HEDIS consists of 75 measures across 8 domains of care.
ILC	Independent Living Center	Entity that provides services to people with disabilities to maximize their independence and to integrate them into their communities.
LTCIP	Long Term Care Integration Project	Project to train doctors, nurses, social workers, in home support services, and other professional care givers to work across disciplines to coordinate patient care.
LTSS	Long Term Services and Supports	Services to assist older adults and people with disabilities accomplish everyday tasks.
-	Managed Care Health Plans	Health plans that belong to a managed care organization.
MCO	Managed Care Organization	A health care network using a variety of strategies to reduce the cost of providing health benefits and improve the quality of care.
	Payor	Entity that pays for services; may or may not also be a healthcare provider

Appendix B

Case Study Tables

Step 1: Design the Service Model

The Need

Table 2 - Case Study: The Need

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What is the primary need we are addressing?	• Healthcare providers need access to a wide array of home and community-based services (HCBS) to improve healthcare outcomes and to reduce healthcare costs. • Healthcare providers do not have expertise in HCBS. There is no single point for providers to secure direct service provision for clients with complex needs. • There is a lack of financial alignment between health and community-based support. The funding is siloed, and there is more funding available for healthcare than for HCBS.

Customer Demographics

Table 3 - Case Study: Customer Demographics

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Who would be the primary users?	• Healthcare providers • Healthcare payors • Consumers, families and caregivers • High risk, medically and socially complex patients/health plan members/clients
Who else would be interested or benefit?	• Home and Community-Based Service (HCBS) providers • Aging & Disability Resource Connections (ADRCs) • Administration for Community Living (ACL) • California Department of Aging (CDA) • California Department of Health Care Services (DHCS) • California Health & Human Services (CHHS) • Centers for Medicare & Medicaid Services (CMS)

How large is the population in need of HCBS?	• 17% of the population in San Diego County is over the age of 60[5] • Approximately 45,000 in San Diego County have one or more disabilities[6] • Approximately 189,300 in San Diego County in 2010 had 3 or more chronic conditions (medically complex)

Current Environment

Table 4 - Case Study: Current Environment

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What changes or new developments might we capitalize upon to address the needs?	• New financial models including incentives, Accountable Care Organizations (ACOs) and new current procedural terminology (CPT) claiming codes. • Care coordination projects such as the Coordinated Care Initiative (CCI), Community-based Care Transitions Program (CCTP) and Center for Medicare & Medicaid (CMMI) Innovation Projects. • Dual eligible special needs plans (D-SNPs) exist in many parts of the country, and they are already providing care coordination. • Affordable Care Act (ACA) growth in new populations. • Growing desire for community knowledge about palliative care and goals of care discussions early in the trajectory of complex illness as well as family-centered planning. • Isolated seniors are aging in place. • Best practices occurring outside of San Diego County (Coleman model care transitions and inclusion of local providers).

[5] SANDAG Series 12 Forecast, 10/14/13

[6] American Community Survey, 2008-12 5yr estimates, Table S1810, accessed June 2014. Population identified by the ACS as having a disability are those who exhibit difficulty with specific functions and may, in the absence of accommodation, have a disability.

The Unit of Service

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Table 5 - Case Study: The Unit of Service

Methods	Description
Per hour	Flat hourly rate; requires robust tracking tools
Per incoming referral (high risk)	Per incoming referral, regardless of how many services are requested
Per service accessed (high risk)	Flat rate per use of service (based on blended costs of all services)
Fee for service	Includes direct and indirect (overhead) costs; may be different for each type of service provided by the brokerage; may also differ across geographic service area
Capitated rate (very high risk)	Limits the dollars expended per client; may require achievement of performance outcomes
Sliding scale	Adjusted based on volume of clients referred or other factors
Shared risk/benefit	Operating entity shares financial risk and potential healthcare cost savings achieved through brokerage services with utilizer

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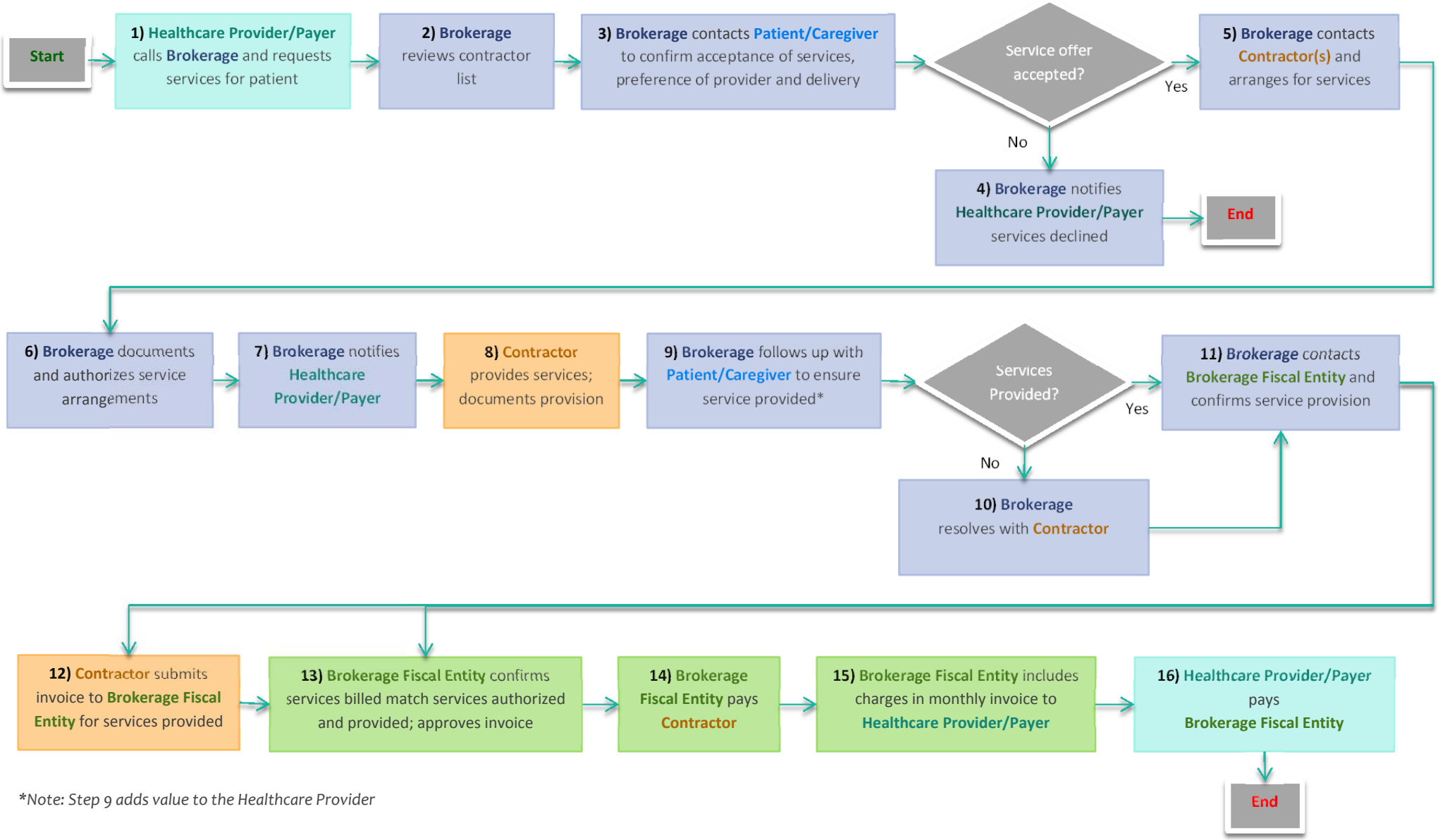
Service Delivery Model A: Referral Only

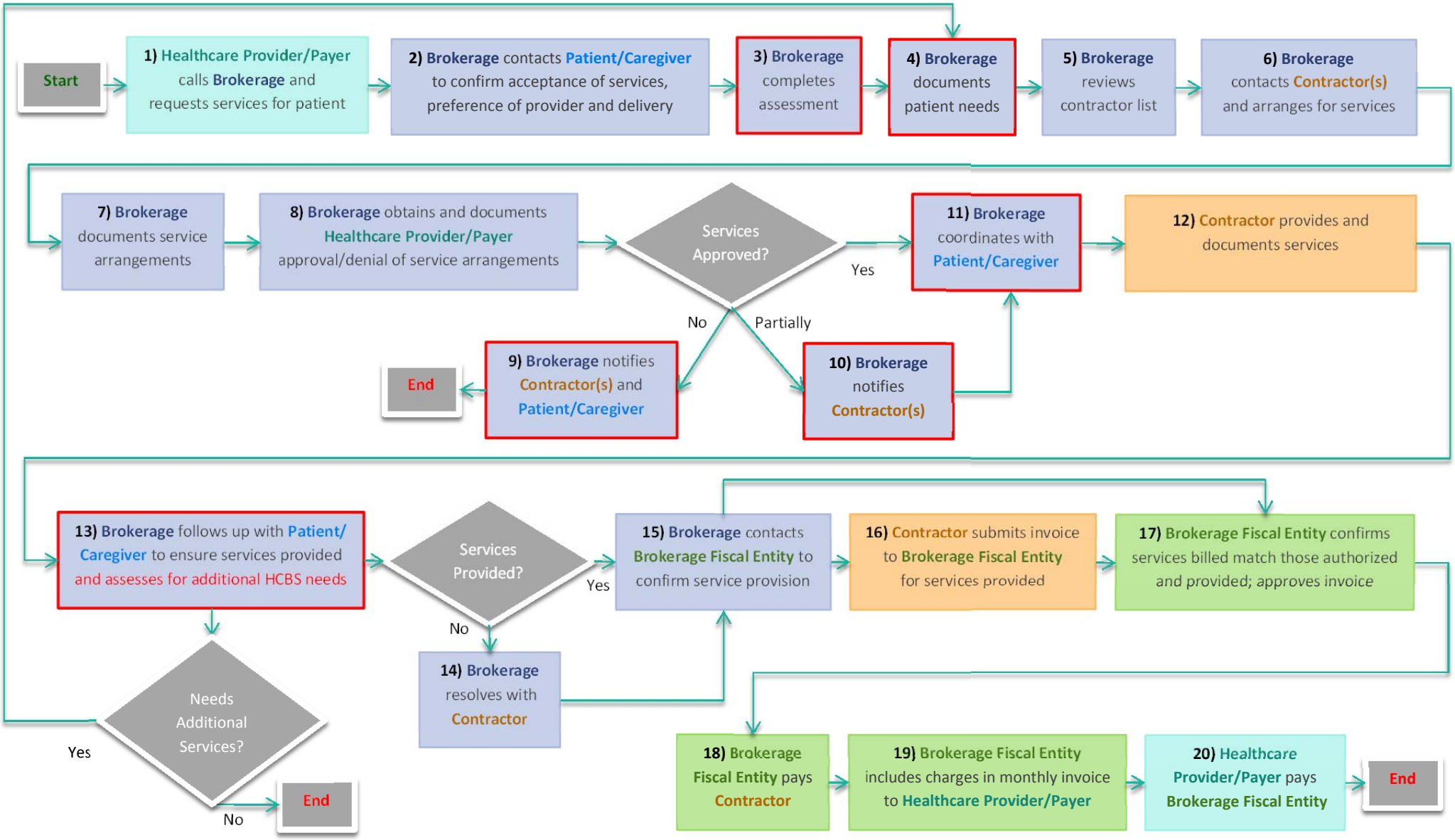
Figure 2 - Case Study: Service Delivery Model A



**Note: Step 9 adds value to the Healthcare Provider*

Service Delivery Model B: Assessment & Short Term Service Coordination

Figure 3 - Case Study: Service Delivery Model B



Note: Steps outlined in red are additional and not included in Model A.

Model A: Referral Only

- Identify the target time factors for key steps
- Develop criteria for healthcare providers to use to determine the patient need to avoid over or under utilization
- Ensure enough follow-up with individual who is referred (important for customer satisfaction)
- Ensure sufficient oversight, and intervention when needed, to achieve desired outcomes

Model B: Assessment and Short Term Service Coordination

- Step 3) Brokerage assessments should be coordinated with other assessments that have been conducted or individuals served by the brokerage may feel overwhelmed and providers/payors may discount the value of the brokerage assessment.
- Step 8) At this point, the care plan should be integrated with the medical healthcare provider/payor care plan.

The Early Business Case – The Value Added

Overall Value

Below is a comparison of the potential value of the two proposed models and the current state, relative to one another.

Table 6 - Case Study: Overall Value

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Service Attributes	Model A: Referral Only	Model B: Assessment & Short Term Service Coordination	Existing State: Uncoordinated Network of Providers	Is Brokerage Better, Worse or Duplicative?
Speed	• One call from provider/payor leads to links to multiple services for referred individual • No need to track down HCBS providers	Same as Model A plus: • The identification of additional needs • Ongoing coordination and follow up	• Find resources • Make multiple calls • Confirm w/patient • Provide post service follow up when possible • Do not assess for needs outside of medical services	Better
Cost of Service	Similar to case management staff costs but lower	Case management staff costs	• Medical staff time for service coordination • Higher healthcare costs due to increased hospital admissions and readmissions, SNF placements, fines and penalties, observation stays, and ER visits • Some MDs paid for very short-term health related (not social services) care transition services for patients post hospital discharge • Providing in-house requires access to many contracts and processing of many invoices	Better
Availability	One single resource – one call away	Same as Model A	HCBS not understood or easily accessible– requires clinician's time and research	Better
Quality	• Knowledgeable referral staff • High quality of service to patients based on contract requirements • Potential provider screening • IT data infrastructure	Same as Model A plus: • High quality service coordination by experienced staff	High paid healthcare professionals working outside of their areas of expertise pulled away from their clinical work	Better

The Customer Experience

Table 7 - Case Study: The Customer Experience

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Customer Experience	Model A: Referral Only	Model B: Assessment & Short Term Service Coordination	Existing State: Uncoordinated Network of Providers	Is Brokerage Better, Worse or the Same?
Awareness of Service	• Provides education to healthcare providers about the value of HCBS • Informs healthcare providers and payors about specific HCBS providers and their services • Provides education to consumers in the community	Same as Model A	N/A – healthcare providers/payors have little awareness of HCBS network and providers, services, fees, geographic areas of coverage, or patient eligibility	Better
Access to Service	Immediate (see Speed in table above)	Same as Model A	Delayed (see Speed in table above)	Better
Use of Service	Single call, follow up provided	Same as Model A	Multiple calls, follow up needed	Better
Payment	• Single invoice per month • Single or no contract with brokerage • Contract monitoring provided to ensure quality	Same as Model A	• Invoiced per patient per provider, so multiple invoices per patient • Contract with each provider • Monitor multiple contracts	Better
Discontinuance of the Relationship[7]	Single or no contract termination	Same as Model A	Multiple contract termination	Better

[7] I.e., when the payer ceases the contractual relationship with the service provider

Key Performance Metrics

The table below compares the *anticipated* performance of the two brokerage models and the existing state, *relative to one another,* in core areas that are important to the customer. The rankings of high, medium and low were used to signify the level of impact each model would be projected to have on improving the respective metric.

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Table 8 - Case Study: Key Performance Metrics

Performance Metric	Model A: Referral Only	Model B: Assessment & Short Term Service Coordination	Existing State: Uncoordinated Network of Providers	Is Brokerage Better, Worse or the Same?
Reduction in per patient healthcare costs overall	Medium	High	Low	Better
Reduction in ER utilization	Medium	High	Low	Better
Reduction in hospitalizations and readmissions	Medium	High	Low	Better
Reduction in out-of -home placements	Medium	High	Low	Better
Improved HEDIS measures for population served	Medium	High	Low	Better

Additional Potential Metrics

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Table 9 - Case Study: Additional Potential Metrics

• Response time standards (on-hold; dispatch of service, etc.) • Caregiver outcomes • HEDIS-like measures tied to the individual's healthcare outcomes • Increase in HCBS services (early metric) • Decrease in HCBS services year over year (later metric-due to improved health outcomes) • Caregiver/family satisfaction with service • Referred individual's satisfaction living at home with the services provided • Healthcare provider/payor's likelihood to use the brokerage again • % of referred individuals who remain living independently in the community	• Retention by healthcare provider/payor of referred individual • % of referred individuals aging with dignity in community--maximizing independence • Quality of life measures • Physician satisfaction with reduced visits for social issues • Decrease in number and length of pharmaceutical treatments • Decrease in in utilization as a result of early intervention • Increase in health care directives over baseline • Quality screening for HCBS providers • Improved population awareness related to goals of care choices • Brokerage's return on investment (ROI) for healthcare provider/payor

Summary Value Assessment

Table 10 - Case Study: Summary Value Assessment

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Do the brokerage models.…	Yes/No	Explain
… provide a significantly higher level of service so that enough customers will really care?	Yes	• Currently, there is no single access to the full array of HCBS in San Diego County. There is a single resource for information, but not for directly connecting patients to providers. • The brokerage should address services gaps and enhance customer satisfaction.
… change the cost/benefit ratio for customers?	Yes	• For those healthcare providers/payors that are required to demonstrate care coordination and reduced healthcare costs, it will provide a considerable cost savings and convenience. • For those healthcare providers/payors that are not mandated to provide care coordination, a positive ROI is anticipated. • Use of HCBS is expected to reduce readmissions and penalties; reduce the number and length of office visits; decrease the intensity of care needs for poor reimbursement programs; and improve patient satisfaction.
… change the standards customers use to judge value?	Yes	• One stop shop for experienced patient service coordination.

Step 2: Identify the Requirements

Start Up Requirements Worksheet

Table 11 - Start Up Requirements Worksheet

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Step in Service Delivery Process	What Needs to Be in Place?	What Must We Do to Prepare?
1) [describe the step]	[list everything that needs to be in place in order for this step to work]	[identify action items to get needs established]
2) Repeat for the remaining steps in the service delivery process.		

Table 12 - Case Study: Workforce

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Staffing Level Considerations	• Call volumes • Expected turnaround times • Level of follow up needed • Capacity
Employee Skill Sets	*Skills Needed* • Coding • Contracts • Understanding of payors • Defined years' experience with client demographics • Strong verbal and communication skills • Strong organizational skills • Strong analytical and problem solving skills with attention to detail • Ability to triage medical versus psychosocial needs • Ability to know which questions to ask • Ability to analyze service needs effectively • Ability to interpret contract regulations • Ability to apply internal quality review procedures *Education Requirements* • Develop education or certification requirements • Licensed supervisors • Master's degree or licensed clinician for completing assessments • MSW-level call center responders • Knowledge of community resources • Case study Model A may use experienced medical assistants • Case study Model B requires a variety of healthcare certifications and licenses
Strategies for Flexible Staffing	*Consider variety of employee types, such as:* • Per diem • Part-time/on-call • Temp • Contract • Shift • Weekend availability • Interns

Strategies for Flexible Staffing (cont.)	*Manage processes* • Manage productivity and flexibility • Evaluate enrollment process to ensure quick response to services • Evaluate policies and procedures to increase capacity and flexibility • Assure referrals are quickly addressed by contractors *Consider use of a mobile, remote workforce* *Cross train* • Find areas where cross training is feasible • Hire staff with broad range of skills who can "float" between roles *General* • Get input from existing call centers • Ensure a minimum number of referrals to gear up and provide services • Consider periods where there may consistently be high volumes, such as the first of the month

Audit & Compliance

Table 13 - Case Study: Audit & Compliance

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Documentation & Reporting Considerations	• Documentation
	  o Retention periods
	  o Regulatory requirements
	  o Contract templates
	  o Standardized forms
	  o Sufficient data to identify trends and assess results of changes
	  o Patient feedback
	• Reporting
	  o What needs to be reported and to whom
	  o Where the information recorded
	  o Ease and simplicity of use
	• Electronic medical records
	• System of internal oversight for audits

Standards & Regulations	• HIPAA and Release of Information Requirements • National Committee for Quality Assurance (NCQA) • Utilization Review Accreditation Commission (URAC) • Commission on Accreditation of Rehabilitation Facilities (CARF) • Standards for hospitals and healthcare providers • Member/participant grievance policy and protocol

Table 14 - Case Study: Legal and Contracting

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Legal & Liability Considerations	*Variables impacting considerations*
	• Services that will be provided to patients
	• Staffing types and licenses (i.e., RNs, LCSWs, etc.)
	
	Liability determination
	• Responsibility:
	  o to follow up;
	  o if the service is inadequate to meet outcomes; and
	  o if something goes wrong during service delivery
	• Exposure the brokerage carries
	• Exposure healthcare providers/payors carry for referring patients
	• Impact on participating entities' existing general liability and legal considerations when participating with a brokerage
	
	Legal documentation for:
	• Clients
	• HCBS providers
	• Referral sources
	• Payors
	• Healthcare providers
	
	Insurance
	• Professional and business liability
	• Medical malpractice
	• Coverage, or lack of, for HCBS providers
	
	Service provider accountability
	• Mechanisms to keep providers accountable and honest
	• Contractor oversight
	• Provider screening including background checks, drug screening, etc.
	
	Regulatory oversight
	• Applicability of Knox Keene requirements
	• Department of Managed Health Care review of the benefit language

Contracting Considerations	*General* • Formal legal documents required between the brokerage and provider • Plans will need to compare costs of brokerage to other solutions • Adapt contract templates for large organizations to fit smaller ones • Contracts should be straightforward and easy to manage for small organizations • Consider unions/labor *Challenges* • Need to determine how brokerage members will ensure sufficient volume • Reimbursement will be the biggest concern *Content* • Standard healthcare industry contractual considerations • Relationship between the brokerage and CBO • Responsibilities and expectations • Description of services being contracted • Staff experience requirements • Screening requirements • Service quality requirements • Service timeliness requirements • Language and cultural accommodation requirements • Punitive actions steps • Liability insurance requirements • Terms of payment/unit price • HIPAA • Data collection • Outcome measurements • Reporting requirements • Flexible terms to accommodate smaller nonprofits

Data Sharing Considerations	*Electronic solutions* • Centralized electronic system • Entities that would have access • Potential for duplicate data entry (entity's and brokerage's systems) *Challenges* • Delivery of data • Levels of provider sophistication - manual to electronic records • Difficult to establish • Must figure out quickly *Importance* • Imperative to have access to and own the data • More important in assessment model with the level of follow up • Aids quality of services • Aids efficiencies • Reduces number of times patients answer the same question • Needed for reporting service outcomes and service value *Extent* • Only with a release from the client • Limited to data needed to provide the level of service requested *Governance* • HIPAA • Contract should address data shared with brokerage, service provider, referring party • Timelines would need to be developed • Clear storage and retention policies
Confidentiality Considerations	*HIPAA compliance* • Application to contractors and entities involved, including non-medically oriented • Standardized HIPAA and patient release forms • Standardized HIPAA training *Information-sharing* • Business Associates Agreement addressing information-sharing • Methods to share information seamlessly • Password-protected, electronic system • Levels of access to records • Liability ownership for breaches

Table 15 - Case Study: Risk Management

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Risks	Mitigations
Capacity	
Insufficient number of service providers	• Aggressive outreach to providers to ensure service providers in all areas
Quality	
Inconsistent or low quality of services delivered by the providers	• Establish formal standards and outcome measures • Establish evaluation process to ensure providers are working within the guidelines of the brokerage
Dissatisfaction with services	• Provide follow up and conflict resolution for consumer complaints • Remove from membership providers (HCBS) with multiple, substantiated complaints
Another layer may reduce response time	• Establish response time for brokerage
Delay in communication	• Establish points in process for timely communication
Legal/Liability	
Who takes on the risk?	• Clarify for all participating entities
Confidentiality/HIPAA	• Clarify for all parties involved (especially consumer) how information is used and shared
HCBS worker malfeasance (theft, inadequate service provision, abuse)	• Secure indemnity agreement • Secure documentation (MOUs, contracts, release of liability forms, etc.)
Legal/regulatory	• Secure legal counsel • Consider Department of Managed Health Care review
Insurance requirements for the brokerage and participating CBOs	• Secure legal counsel
Financial	
How do you pay for the brokerage? Who pays for the services?	• Research cost to run brokerage to ensure brokerage remains viable and intact
Not enough funding to cover costs/ develop service	• Establish guaranteed reimbursement rate/minimum quantity
Administration cost	• Determine operational/administration cost for lead entity
Pricing	• Develop flexible contracting strategy with built in cost adjustments
Concern about additional costs with brokerage model	• Ensure a positive ROI and communicate it

Risks	Mitigations
Oversight	
Who provides oversight for brokerage (makes sure it is fair, handles grievances, etc.)?	• Establish decision-making management structure with representation from all impacted parties • Look at how brokerage would bring on, and even vet, HCBS providers
Who will provide oversight for contractors?	• Brokerage?
Appeal procedures	• Plan, fair hearing, brokerage input needed
How will brokerage be regulated?	• Determine governance structure before implementation
Standards of service	• Establish standing oversight subgroup to develop and monitor
General	
Overly complex administrative burden on providers	• Brokerage agency assume most of the burden
Lead agency/CBO development	• Work with pilot funder to develop further
HCBS brokerage replication	• Document and share brokerage design and implementation to support replication in other communities
Service fragmentation requests	• Define benefit limitations and exclusions

Step 4: Select the Business Model

Summary of Differences between LLC and S Corp

Table 16 - Summary of Differences between LLC and S Corp

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	LLC	S Corp
Ownership	LLCs can have an unlimited number of members	S corps can have no more than 100 shareholders (owners).
	Not restricted.	S corporations cannot be owned by C corporations, other S corporations, LLCs, partnerships or many trusts.
	LLCs are allowed to have subsidiaries without restriction.	Restrictions apply.
Ongoing formalities	LLCs are recommended, but not required, to follow internal formalities.	S corporations face more extensive internal formalities.
	Adopting an operating agreement, issuing membership shares, holding and documenting annual member meetings (and manager meetings, if the LLC is manager-managed), and documenting all major company decisions.	Adopting bylaws, issuing stock, holding initial and annual director and shareholder meetings, and keeping meeting minutes with corporate records.
Differences in management	Owners of an LLC can choose to have members (owners) or managers manage the LLC. When members manage an LLC, the LLC is much like a partnership. If run by managers, the LLC more closely resembles a corporation; members will not be involved in the daily business decisions.	S corps has directors and officers. The board of directors oversees corporate affairs and handles major decisions but not daily operations. Instead, directors elect officers who manage daily business affairs.
Existence	Some states require LLCs to list a dissolution date in the formation documents. Certain events, such as death or withdrawal of a member, can cause the LLC to dissolve.	An S corporation's existence is perpetual.
Transferability of ownership	LLC membership interest (ownership) typically is not freely transferable—approval from other members is often required.	S corporation stock is freely transferable, as long as IRS ownership restrictions are met.
Self-employment taxes	The owner of an LLC is considered to be self-employed and must pay the 15.3% self-employment tax contributions towards Medicare and social security. As such, the entire net income of the LLC is subject to this tax.	S corporations may have preferable self-employment taxes compared to the LLC because the owner can be treated as an employee and paid a reasonable salary. Corporate earnings after payment of the salary may be able to be treated as unearned income that is not subject to self-employment taxes.

Step 6: Implement!

Marketing Strategy

Table 17 - Case Study: Marketing Strategy

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Target Audience	Key Message(s)
Healthcare Providers	
Healthcare providers	○ One phone call does it all to get HCBS for your patients ○ No need to navigate the maze of services ○ Let the brokerage be the expert in HCBS and the medical staff can focus on patient care ○ Streamline community linkage ○ Reduce readmissions by easily connecting your patients to community-based services ○ New way to access services ○ Ease, value and quality
Hospitals	○ Brokerage is here to help ○ One stop shop ○ Quick response ○ Accountability
Hospital discharge planners	○ Brokerage can help locate community services ○ Brokerage can help with the continuum of care when the patient is back home
Physicians	○ Is your patient at risk of nursing home placement or unnecessary hospitalization?
Skilled nursing facilities / acute rehab units	○ One stop shop ○ Quick response ○ Accountability
Providers/Payors	
Accountable care organizations (ACOs)	○ One stop shop ○ Quick response ○ Availability ○ Service expertise ○ Accountability
Managed care organizations (MCOs)	○ One stop shop ○ Quick response ○ Availability ○ Service expertise ○ Accountability ○ Easily connect your patients with community-based services

Target Audience	Key Message(s)
Payors	
Health plans	○ The answer to all your post-acute concerns ○ Brokerage can help you control costs and satisfy your members ○ New way to access services ○ Ease, value and quality
Insurance groups	○ Streamlined regional access
HCBS Service Providers	
HCBS providers	○ Decrease bureaucracy with centralized referrals and billing ○ Brokerage can help provide business and simplify billing ○ Increase or get new referrals from medical offices, insurance companies, etc.
HCBS program offerings	○ Increase exposure and clientele ○ Generate more diverse revenue streams
Non-governmental organizations (NGOs)	○ Get on board or you will be left behind
Individuals and caregivers	
Family caregivers / individuals	○ One stop shop ○ Streamlined service delivery ○ Fast and efficient ○ New way to access services ○ Ease, value and quality ○ Access to an array of quality services ○ Lighten the load so the family caregiver can spend quality time with their loved one ○ Useful for families who live out of state
Others	
Others who might operate the brokerage (i.e., IPOs such as Mobile Doctors Group and Home Health Agencies)	○ One stop shop ○ Quick response ○ Availability ○ Service expertise ○ Accountability

Table 18 - Case Study: HCBS Support Needs

Return to Guide

Support Needs	
Accompaniment to medical appointments, etc.	Medication management
Adult protective services	Moving services
Advocacy, assistance applying for services, benefits education	MSSP
Care coordination/transitions	Non-urgent provider home follow up
Case management services for caregivers	Pain management
Community-based adult services	Paramedical services
Community resource referrals	PCP (Person-centered planning?)
Counseling services for caregivers	Personal care/assistance
Dental services	Personal emergency response systems
End of life care	Placement services
ERS	Prescription co-pays
Financial assistance for medical supplies	Pharmacy-mobile
Financial literacy	Prevention
Health services and care	Respite support for caregivers
Home modifications/repair	Safety inspections
Housekeeping/cooking	Senior centers
Housing	Shopping/errands
In home supportive services	SNF repatriation
Legal assistance	Social support/visitors
Linkage to resources for all payors	Translation
Meals/nutrition	Transportation
Medical/non-medical call assistance (nurse/social worker triage assistance and possible home visit to avoid ER)	Veteran service coordination
Mental health	Warm handoffs to facilitate timely follow up

Home & Community-Based Services

Brokerage Design Guide

Prepared by: