



**JOINT
LEARNING
NETWORK**
For Universal Health Coverage



Fundamentals of Contract Management of Private Sector Healthcare Providers

Mini-Guide

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About this Mini-Guide

This Mini-Guide was produced by the Joint Learning Network on Universal Health Coverage's Virtual Learning Exchange on the Private Sector, which took place between March and June 2022. It distils the key lessons, frameworks and case study that were co-produced during the course of the 'Contract Management' work stream of the learning exchange. The primary aim is to build a foundational understanding among public payers and governments about how to monitor, manage, and enforce contracts for subsidized healthcare services with private healthcare providers.

The mini-guide addresses the following key questions:

- What is contract management?
- Why is contract management of private providers important?
- What would an ideal system of contract management look like?
- How did one country (India) develop and improve its mechanisms for contract management as part of its new national health insurance reform AB-PMJAY?

A separate mini-guide 'Fundamentals of Harnessing Private Capital for Universal Health Coverage' was also produced from the work of the 'Private Investment' workstream of this learning exchange.

What is contract management?

A growing number of governments pursuing Universal Health Coverage (UHC) are doing so by contracting private providers to deliver subsidized health services on their behalf (WHO n.d.; Thomas et al. 2016; Roland et al. 2019; World Bank Group 2018; and Abuzaineh et al. 2018). This might be for a specific vertical program, such as TB care, or services in a defined geographic area. Increasingly, however, there is a shift towards much broader contracting of private providers for comprehensive services as part of mixed delivery systems (WHO 2020). This is a common feature of countries implementing national health insurance reforms, whereby beneficiaries can choose to seek care at any empaneled provider (public or private) and ‘money follows the patient’.

Managing this expanding scope and scale of contracting presents a significant challenge for governments and payers. A great deal of attention rightly goes into the ‘pre-award’ activities in the contracting cycle (See Figure 1), such as defining the scope of service, the payment mechanism, and performance indicators. The enormous effort of enrolling, empaneling and onboarding sufficient private providers means that the final stage of the contracting cycle, monitoring and managing the contracts, often gets overlooked – at least until things start going wrong.

Scope of this mini-guide

The focus throughout this mini-guide is on post-contract award activities with private providers of healthcare services, where private providers are defined as any non-state entities. Contracts for healthcare products, supply chain or back-office functions are not covered.

Figure 1: The contracting cycle



Source: Jerry La Forgia, elaboration based on Loevinsohn, 2008; La Forgia et al., 2005; WHO/IFC, 2020

Contract management is “the process of actively managing contract implementation to ensure the efficient and effective delivery of the contracted outputs and/or outcomes” (World Bank Group 2018). For the purposes of healthcare services, it involves the payer or government making sure that the healthcare it is

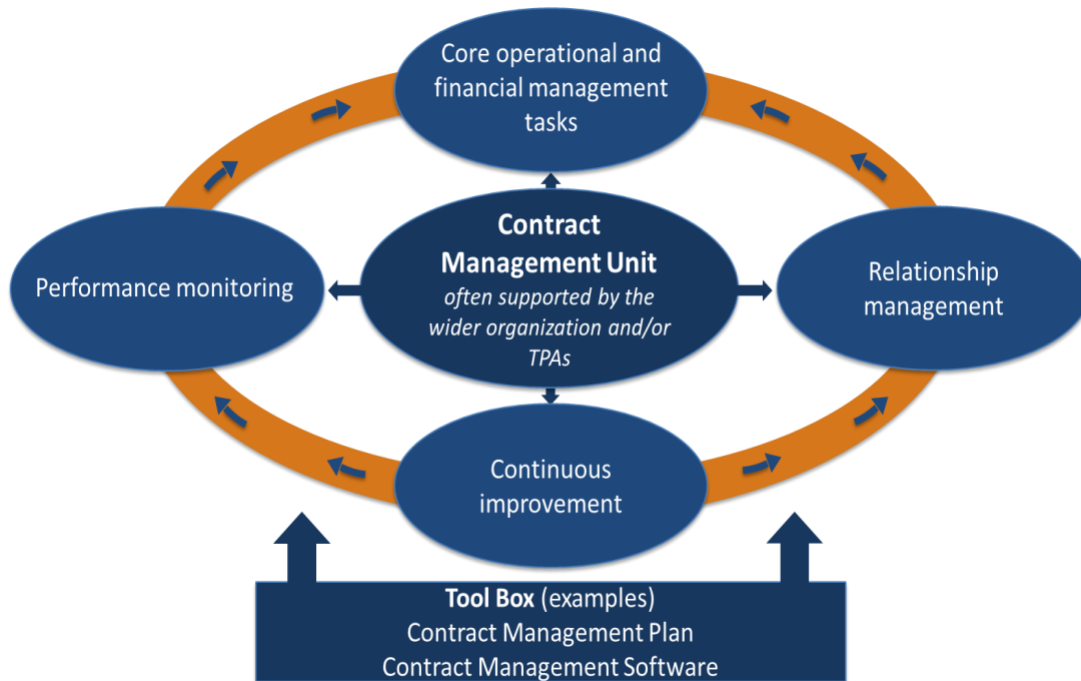
paying the private contractor to provide is being delivered at the right levels of quality, quantity, timeliness and cost.

The most important objectives of contract management are therefore to:

- Ensure that reported activities and services are in line with contract specifications
- Ensure that the reports on performance accurately describe the status of service delivery
- Ensure that services are delivered with quality, responsiveness, effectiveness and efficiency
- Foster continuous improvement

In terms of how this is done, the key tasks and functions of contract management are displayed in Figure 2, and described below. Typically, a dedicated contract management unit takes the lead in performing these functions, but many are also distributed. For example, many staff in a payer may share the responsibility for managing a relationship with key private providers and ensuring that they are performing as required. Equally, some payers opt to contract-out elements of contract management itself because they do not have the skills or capacity to do it in-house. So called Third-Party Administrators (TPAs) may be brought in to assist with administration of contracts, providing independent audits of provider compliance, or in some cases entire lifecycle management of contracts on behalf of the payer.

Figure 2: Key features of a contract management system



Core operational and financial management tasks: The core administrative processes of contract administration involve management of finances and payments, assessing and tracking contract risks, ensuring that governance and accountability arrangements set out in the contract are followed, providing reports to senior management, record keeping and managing changes required to the contract during its term. To the extent possible, much of this functional area should be digitized and automated to support efficient and timely administration.

Performance management: This functional area is focussed on assessment of the real-world performance of providers against the contracted terms, such as whether services are being provided to the population required, to the right standards, resulting in the anticipated benefits/outcomes, and whether there are any complaints or failings that need addressing. Much of this will be reported by the providers themselves, but it is important to have independent monitoring mechanisms to verify this information, and the capacity to conduct more detailed investigations into the root causes of any areas of under-performance. This might involve independent surveys and inspections 'on the ground' or analysis of data across different providers to compare performance.

Relationship management: All other aspects of contract management are made harder if there is no mutual trust and understanding between the two parties. Relationship management involves ensuring there is regular, meaningful communication between payer, provider and other stakeholders, to ensure that they understand the others concerns, can troubleshoot issues and disagreements before they escalate, reduce information asymmetries and give a window in either organization or the wider healthcare system.

Continuous improvement: Good contract management is not just about fulfilling the letter of the contractual obligations, but also fostering continuous improvement among providers so that they are supported and incentivised to improve what they do. This might be through sharing best practices, encouraging partnership working across providers, making new market intelligence available and incentivizing or signposting the areas that it is most important to see improvements from the payer perspective. This applies to the payer too, and many contract management units will also review their own organization's performance as a partner by periodically asking providers about their experience of working with them.

Contract management toolbox: Not as a function in itself, but an enabler of all others, two important tools in the toolbox of all contract management systems are the contract management plan and contract management software. A contract management plan sets out all the responsibilities and tasks of contract management across the organization at a detailed level, including processes for authorizing changes to the contract, managing risks, dispute settlement and 'exit' arrangements. This includes making the roles and responsibilities of different agencies clear, as there can often be confusion, fragmentation and even conflict between payers, policymakers, regulators and other key actors as to whose responsibility it is to manage different aspects of private provider performance. In terms of software, a wide range of off-the-shelf packages are available to create a central, searchable repository for contract management information, including dashboards to easily monitor different contract management functions and indicators.

Why is contract management of private providers important?

As described in the previous section, purchasers tend to put a great deal of resources and focus behind the 'pre-award' activities of contract drafting, provider selection and payment design, but fail to put the same investment into post-award activities of monitoring performance and managing providers. As a result, contract management was described as many payers' 'Achilles Heel' by participants from JLN member countries, who noted it as a weak spot in their organizations use of private providers (See Figure 3).

Figure 3: What do public officials say about their contract management of private providers?



Source: Quotations from public official participants in the JLN Virtual Learning Exchange on the Private Sector

Weak contract management can lead to a variety of significant problems for payers and purchasers of health services, including:

- Inability to determine whether money spent is producing results
- Insufficient levers to encourage (or force) providers to change
- Inability to detect and prevent fraud and gaming
- Encouraging providers into a 'compliance mindset' rather than offering the best service they can
- Regular disputes with providers over conflicting interpretation of contract terms
- A reactive, rather than proactive approach to problems that (inevitably) arise

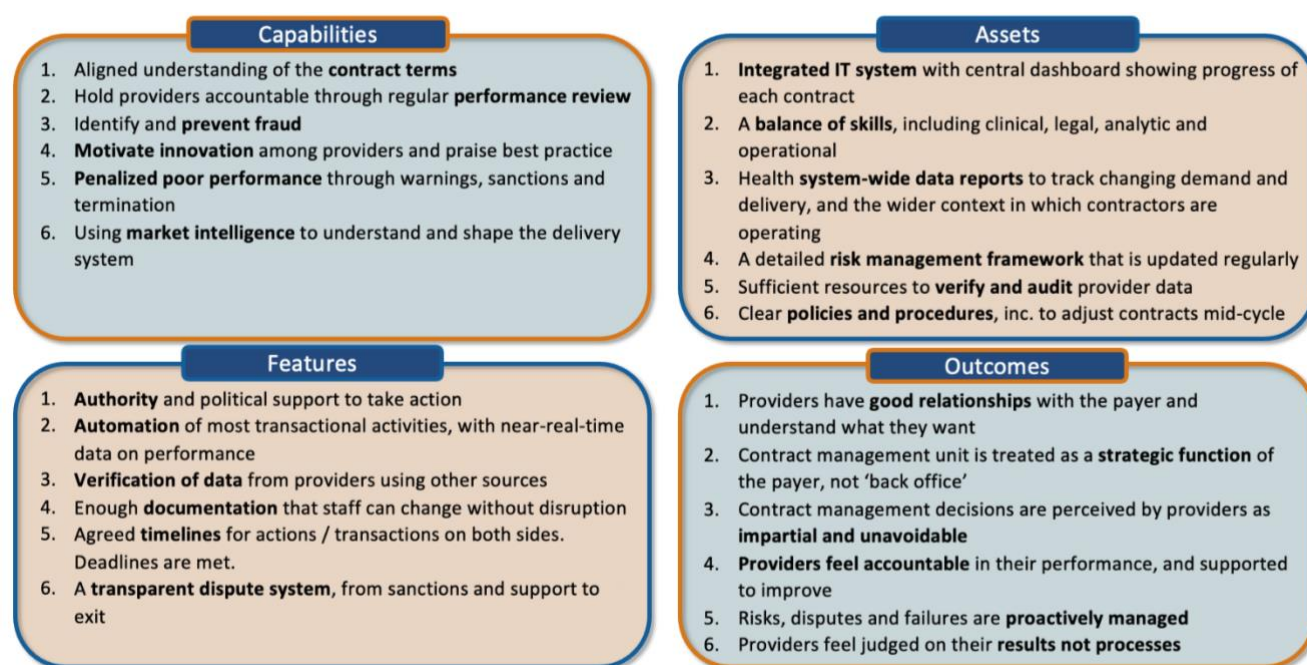
These problems arise under weak contract management of all types of providers, but with private healthcare providers the issues are particularly acute. Firstly, this is because there often aren't the informal mechanisms that exist with contracted public providers to resolve issues (e.g. a 'quiet word' between the Ministry of Health and a hospital director). Second, there is an additional motive – profit – that may lead private providers to adhere more to the letter of their contract than the spirit. Third, in some systems private providers may have been managing contracts for many years, meaning there is gap in experience between payer and provider that favours the latter. Fourth, public officials and purchasers may have less experience (and information) on how private providers are run, such as their cost base, which allows them to be more easily misled regarding their performance.

Ultimately, good contract management will lead to the purchaser getting the maximum possible value for their money, and a continuously improving private delivery system whose providers are happy and motivated to work with government and invest in this for the long-term. Whereas poor contract management will lead to poor service for patients, public discontent around mis-spent funds, and an environment of distrust between payer and providers that further fuels short-termism and compliance-focussed behaviours that will weaken healthcare delivery over time.

What would an ideal system of contract management look like?

Recognising the many facets of a good contract management, and the different ways that success could be defined, participants on the JLN Virtual Learning Exchange on the Private Sector worked to co-produce a framework to describe what an 'ideal' system of contract management would look like.

Figure 4: Framework to define an 'ideal' system of contract management, monitoring and enforcement



The resulting framework (Figure 4) shows incorporated four separate categories for public purchasers to consider how their current system deviated from this ideal:

Capabilities: These define success according to what the purchaser of capable of *doing* to monitor and manager private providers, including both technical skills such as spotting fraud and soft skills such as motivation and praise.

Assets: These define success according to the *tools* available to an ideal contract manager, including integrated IT system for performance management and administration, resources to independently verify data and the right mix of skills.

Features: These define success according to the *ways of working* regarding contract management, including sufficient authority to take action, automation of most administrative work, timely and responsive task execution and sufficient resilience as to withstand staff

Outcomes: These define success according to the *results* that an ideal contract management system should foster, including mutual trust, respect and understanding between payer and providers, the majority

of deviations dealt with proactively, and a general sense of contract management being treated as a strategic rather than administrative function within the purchasing agency.

The framework offers could be developed further in subsequent phases, but is a useful checklist against which public officials can compare their current state of contract management and identify priority actions for improvement based on the gaps (an exercise the participants then did individually for their own systems).

Box 1: Seven 'sins' of contract management: common pitfalls for payers to avoid

In addition to this ideal framework, speakers at the learning exchange also noted the reverse perspective – things to make sure not to do that had caused problems in other systems. Seven particular pitfalls stood out:

1. Getting lost in the process of contract management, rather than focusing on results
2. Micro-managing providers – removing autonomy reduces their scope to innovate
3. Failing to independently verify provider reports – seek input from patients, inspectors and cross-provider data analytics to check what is being presented is true
4. Under-resourcing the contract management team – this is a strategic department that requires specialist (especially clinical) skills, not a purely administrative function
5. Thinking only about provider performance, not payer performance – purchasers sometimes demand total compliance to contract terms from their providers without doing this themselves (e.g. paying irregularly). Over the long-term this will decrease providers' willingness to work with government
6. Acting weak or acting slow – if other providers see that poor performance is tolerated or leads to only modest sanctions, they may take their own performance less seriously
7. Being overly rigid – providing healthcare at scale is unpredictable. Complex contracts often need to change and adapt as the sector shifts.

How did one country (India) develop and improve its mechanisms for contract management as part of its new national health insurance reform AB-PMJAY?

Source: With grateful thanks to Dr Sudha Chandrashekar, Executive Director for Health Policy & Hospital Engagement Assurance, National Health Authority, India

In 2018 India launched a new nationwide healthcare coverage scheme for almost 500 million of its poor and vulnerable citizens - *Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana*, or AB-PMJAY. The scheme was able to launch quickly because a precursor system of coverage for the poor – RSBY – had been active in many states since 2018, and so public and private providers empaneled for those state-level schemes could be immediately auto-enrolled.

The speed of implementation was regarded as a remarkable success from a coverage perspective, but left an enormous contract management challenge. Within a few years of its creation, the National Health Authority (which was responsible for AB-PMJAY) was overseeing an active scheme with more than 20,000 empaneled providers across more than 30 states.

Drawing on the best practices of states whose forerunner schemes had been most successfully run, such as Andhra Pradesh and Karnataka, the National Health Authority (NHA) sought to implement several core principles across its contract management approach.

First, every aspect of the contract management process should be digital by default. This meant empanelment and contracting were all done digitally, and data fed back by the individual states administering AB-PMJAY would all be digitized, standardized, and interoperable. This has allowed NHA to create an IT system that supports its oversight through multiple dashboards of key metrics that it can track at any level of granularity, from the federal level right down to individual hospitals.

Second, has been to use to ensure that NHA is an efficient and attractive ‘customer’ from the provider perspective. This principally means making sure that payments made are timely – a frequent frustration of RSBY payments, which could take months in several states. Processing and payment resolution times were therefore one of the most important metrics that NHA monitored each state on, with poor performing states investigated to help resolve bottlenecks and inefficiencies. There is still scope to improve this, leading to so-called ‘green channel’ payments now being piloted whereby trustworthy providers would receive a proportion of their payment immediately when a claim was submitted, with the remainder sent after the usual claim resolution had been done.

Third has been to ensure that providers regard AB-PMJAY as ‘firm but fair’ when it comes to deviations from agreed contract terms and required standards. Guidelines of ‘de-empanelment’ of providers are just as detailed as those for empaneling them – setting out all of the actions that will be enacted for different types of failures (e.g. denying services to patients, charging illegal payments, submitting an incorrect claim etc.). Actions include a range of escalating sanctions, including fines, withholding payments, de-empanelment from the scheme and legal action. In such cases it is important to issue clear documentation and early warnings wherever possible so that providers have an opportunity to improve before these are

necessary, and also do not feel unfairly treated if they are punished. It is also important to publicize sanctions when they happen, as it shows other providers that poor performance is not tolerated.

At the same time, NHA wants providers to feel that they have listened in such cases and are not rigidly implementing sanctions when there is a reasonable explanation. For example, some rural providers were failing to meet AB-PMJAY's requirements for timely diagnostics but pointed out that this was because there were no labs within an accessible distance, and so an exception was agreed.

Third has been to use the principles of strategic purchasing to actively manage and capacity plan the provider sector – targeting contracts with private providers where they address gaps in the public sector delivery system and add maximum value to the networks. AB-PMJAY could not operate without private providers, who make up around 60 percent of India's hospitals, but at the same time it needs to be able to de-empanel these providers or it will lose its most powerful lever as a provider. Planning 'back-up' capacity has enabled it to stand up to providers threatening strike action in some states – de-empaneling those that went ahead with it for one year while maintaining service through public providers and private ones that chose not to strike.

Fourth has been to not neglect the human side of relationship management with providers, despite AB-PMJAY's vast scale. NHA will seek broad consultation when making significant policy changes that will impact providers, such as the current process to implement DRGs. It also conducts Program Inter Coordination Unit Visits, where multiple staff from different departments of NHA and the states visit hospitals to understand their issues, review any grievances and ensure good communication at the personal level. NHA also targets outreach of its own senior officials to non-empaneled or inactive hospitals to show them that their participation in the scheme is still welcomed and that it can be flexible to any individual requirements that the hospital might have.

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