The Four Knows and Tips of Contracting with Managed Care Organizations

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The Four Knows of Contracting

1. Know the Rules
2. Know What the MCOs Need/Want?
3. Provider Know Thyself
4. Know your Contracting Strategy Options
1. Know the Rules

• What does the state proposal to CMS for managed care for duals say?
• What does the State’s Request for Proposal to the Managed Care Organizations say?
• What other information is available from the State agency administering the program about the program?
1. Know the Rules: Program Basics

• When does the program start? Is it phased-in? If so, how/where?

• Who is the target population?
  – Medicaid only, full duals, certain geographies

• What are the target conditions (e.g., diabetes, COPD, CHF)?

• What are the requirements? How will the program work?
  – e.g., care coordination, medical home, risk assessments, etc.

• What are the state goals (e.g., reduce hospitalizations, reduce costs, etc.?)
1. Know the Rules: Network & Contracting Requirements

- Distance/Access requirements: What are the state requirements around beneficiary access to providers by provider type?
  - e.g. LTC providers cannot be more than 20 miles away in urban settings, 60 miles or less in rural

- By what date, must MCOs demonstrate they have a sufficient network of providers? (component of state readiness review of the plans)

- Must MCOs contract with all Medicaid providers for the initial contracting period?
1. Know the Rules: Reimbursement

• Did the state set a rate floor or can MCOs negotiate any rate with providers?

• Must MCOs consider alternative payment models beyond FFS?

• Are MCOs required to share any of their payment incentives with providers?
1. Know the Rules: Metrics

- What performance and/or quality metrics are the MCOs held accountable for by the state?
- Which ones are tied to incentive payments, if any?
- What metrics are the state tracking via claims or requiring to be reported by MCOs and/or providers as part of the program?
2. Know the MCOs or Plans: What do they want?

*They want what any accountable, financially at-risk organization wants, to:*

- **Meet their contractual obligations**
  - Provider network adequacy
  - Compliance with state contractual requirements (e.g. claims paid within prescribed time, care coordination, appeals process)
  - Perform on designated quality metrics tied to P4P incentive payments

- **Access to right care at the right place at the right time for their members**

- **Standard contracts with providers**
2. Know the MCOs or Plans

- Spend less on beneficiaries’ health care costs than they receive from the state = Make a Profit
  - This is achieved by:
    - Ensuring members get right care at the right time
    - Care management/coordination/preventive care
    - Interdisciplinary care teams
    - Redesigning care
    - Substituting lower cost care when it can achieve good patient outcomes
    - Avoiding higher cost care (e.g., hospitalizations)
2. Know the MCOs or Plans

- What does their standard contract say?
- Do they pay on time?
- Will they help educate your office staff?
- What do other providers think of them?
- Is there a merger in the works?
- Are they financially stable?
- Can they use your name in their advertisements?
2. Know the MCOs or Plans

- Are there any pending litigations with other providers?
- Ask other providers about the MCOs level of service and satisfaction
2. Know the MCOs or Plans: Contract Terms

- **Medical necessity**: who determines it? Where are the criteria posted?
- What is the contract **term**? Is there an automatic renewal provision or annual rate negotiations?
- What are the **termination** provisions?
- What is the process for determining patient eligibility for services? (E.g., web, telephone)
2. Know the MCOs or Plans: Contract Terms

- Does the plan require **other information** beyond that submitted on a clean CMS1500 or UB92?
- Who is responsible for **coordination of benefits** – the plan or the providers?
- What are the **dispute resolution** provisions/process?
- What services can be billed to plan enrollees (e.g. non-covered services, co-pays, deductibles)?
3. Provider Know Thyself

• What populations do you serve?
  • Chronic Conditions
  • Acuity
  • Geographies

• What services do you provide today?

• What other services are you willing to provide or populations would you serve, if reimbursed?

“Tell them your story”
3. Provider Know Thyself

• What is your quality?
  • Performance
  • Dashboards

• What is your model of care?
  • Person-centered, social model, medical model
  • Best practices
  • Specialties
  • Staffing model
3. Provider Know Thyself

• How much risk is your organization willing/able to take?
  – This will determine the types of reimbursement models you will want to negotiate

• What is your payer mix?
  – Do you need Medicare and Medicaid revenues?
Provider Know Thyself (continued)

- How much risk are you willing/able to take?
- What is your payer mix?
  - Medicaid dependence
- What are your key referral sources and physician doing? Which providers see your residents?
  - MCOs should want all of you in the network
  - Possible partnerships → lower cost of care
4. Know Your Options: Contracting Strategies

- Be vocal and proactive

- Read the MCO/State contract so you know your rights and the MCOs obligations

- Bring your own statistics about your organization and be prepared to discuss your value proposition

Where do you have leverage?

- **Network:** Are you the only provider in a given geography? Do they need you to meet network adequacy?
- **Quality:** Do you have the highest quality or value in comparison to others?
4. Know Your Options: Contracting Strategies

• Don’t be defensive.
  – Talk about desire to “partner”
  – The MCOs want to make a profit but remind them they need you to be solvent too.
  – Plans will contract with the easiest organizations and those that can deliver the greatest volume first.

• Be Part of the Solution
  – Who are the MCOs problem cases? Situations? (e.g., clinically complex patients, care coordination, etc.)
  – Consider approaching the plans’ foundations for grants to pilot certain services or care delivery redesigns
4. Know Your Options: Contracting Strategies

Alternative Reimbursement Models *(to enhance your Medicaid reimbursement)*

1. Pay for Performance *(sliding scale vs. all or nothing)*
2. Bundled payments
3. PMPM arrangement
4. Shared savings

• Propose alternative rates or additional services for which you can be reimbursed

Escalate: If your contracting contact cannot approve alternate arrangements or language, talk to their Director or in certain circumstances talk to plan CEO/COO for your state.
4. Know Your Options: Contracting Strategies

• What are the consequences if you don’t sign a contract?
  – What are your key referral sources and physicians doing? Are they contracting?
  – Are you required to contract with MCOs by the state?
  – Would you have to accept a lower FFS rate?
  – Would you lose referrals?
Tips for

THE NEGOTIATION & CONTRACT
Bring to Negotiation

• Your Value Proposition
  – Describe your organization and its non-profit value
  – Demonstrate Your Quality
    • Dashboards with performance metrics

• Your Questions
  – Ask what they are trying to achieve and how your organization might be able to help.
Additional Managed Care Contracting Tips - “Page One” Issues

• **Caption**
  – Correct entity names-make sure both parties names are legally correct.
  – Effective date

• **Recitals**
  – High-level description of the purpose of the agreement
  – Courts may look to the recitals for context and the parties’ in the event disputed terms are ambiguous
  – Incorporation into the agreement
Managed Care Contracting Tips - Definitions

• **Plans, Payors and/or Clients.** Ensure these terms are not defined overly broad to avoid inadvertently agreeing to discounted rates for services furnished to broader scope of individuals than you intended.

• **Covered Services.** Your principal obligation under the agreement is to furnish “Covered Services” to the Plan’s members. Ensure this term is carefully defined in light of the full scope of services you intend to provide and for which you expect to be paid. Where possible, consider listing and defining each service by developing a separate schedule.

• **Medical Necessity.** Ensure that the definition of “medical necessity” does not give the Plan the sole authority to determine what is medically necessary. Instead, the definition should rely upon the clinical judgment of the Provider and/or community standards.

• **Standard of Care.** Avoid provisions that impose a duty on you to furnish the “highest” or “best” quality of care. These types of provisions can enable Plans to prevail more easily in a breach of contract action, and they might give an easier path in medical malpractice claims.
Managed Care Contracting Tips – Your Obligations

• **Delivery of Services.** Ensure that you not only know the scope of covered services under the contract but also any terms and conditions regarding the delivery of those services (e.g., prior authorization requirements, qualifications of the caregiver, etc.)

• **Records Requirements.**
  – Does the contract impose records maintenance and/or retention obligations that differ from your standard practices?
  – Consider negotiating a general provision stating that Provider must retain patient records for the period prescribed by applicable state and federal law.
Managed Care Contracting Tips – Your Obligations (continued)

- **Policies and Procedures.**
  - Watch for provisions that are incorporated by reference such as the Plan’s policies, guidelines or other standards. Obtain copies of any such documents before executing the contract.
  - Ensure that the contract does not permit the Plan to change those standards and enforce them under the contract without advance notice to you.
  - Ensure that you are aware whether the contract or the standards govern in the event of a conflict between the two.

- **Audits.**
  - Carefully review the Plan’s rights to conduct audits and who pays for the audit.
  - Does the contract allow the Plan to use statistical methods to project alleged over-payments?

- What is the look-back period for audits?
Managed Care Contracting Tips – Your Obligations (continued)

• **Utilization Management.**
  
  – Understand who at the Plan performs utilization management (e.g., qualified clinicians).

  – Understand how member eligibility is verified.

  – Understand how much time the Plan has to respond to prior authorization requests.

  – Know your appeal rights in the event you disagree with a Plan decision.
Managed Care Contracting Tips – Claims Payment

- **Time Period and Process for Submitting Claims.** Compare to your standard practices and consider negotiating “special circumstances” provisions to permit you additional time in certain situations.

- **Who is Responsible for Paying You and What is the Timeframe?**

- **Nonpayment.** In addition to the right to terminate, the Provider would desire the right to suspend services and impose penalty fees in the event of non-payment by the Payor (or other entity responsible for payment).

- **Retroactive Denial of Claims.** Consider negotiating provisions that prohibit the Plan from retroactively denying claims that were positively adjudicated absent fault or fraud of the Provider. Consider also negotiating cut-offs for any look-back time periods.
Managed Care Contracting Tips – Term/Termination

- **Contract Duration.** Ensure that it is clear. Future rate uncertainties might suggest a longer term.

- **“Without Cause” Termination.** Carefully review the terms of the proposed contract. Consider negotiating a mutual right to terminate without cause with reasonable advance notice periods and clear requirements for submission of prior claims post-termination.

- **For Cause Termination.** Consider including a cure period for any alleged “for cause” termination reason. For cause termination can have collateral impact for providers in certain situations, and therefore providers should ensure that the standards are clear.
THE HOT POINTS

• Certification/Credentialing
• Case Management Coordination
• Audits/Overpayments
• Manuals and unilateral amendments
• Dispute resolution
• Encounter Data
Hot Point: Certification/Credentialing

- **Licensure** - Why isn’t licensure/Medicare/ Medicaid enough
- **Checklist** - ask for requirements
- **Time limit to make determination** - can take up to 6 months for approval once submitted
- **Provisional credentialing** - ask for “provisional” status so claims can be processed for payment while process for full credentials approval is pending.
Certification/Credentialing:
What is generally required?

• **Licensure** - State and Medicare/Medicaid provider information

• **Accreditation** - JCAHO, CARF, CHAP, CCAC etc.

• **Survey History** - State and Federal

• **Language competencies**

• **Verification of credentialing** - staff both Internal and Outsourced

• **Insurance certificates**

• **Attestations** - Malpractice and other negative events

• **Site Visits** – generally for nonaccredited facilities
Hot Point:
MANUALS AND UNILATERAL AMENDMENT

• **Manuals:** Read the manuals for utilization criteria, authorization guidelines, quality measures, etc.
• The manual is the contract
• **Unilateral Amendments:** Look for negative notice provisions that require you to notify the MCO to opt out of future amendments to the agreement.
• **Incorporation of other contracts,** such as the state contract and other product lines
Hot Point: Dispute Resolution

• Each MCO is different
• **Purpose:** To avoid going to court
• **Beware of contracts** that permit the MCO contract manager to make the final determination
• Make sure you **retain the right to go to court,** if the process fails you.
Hot Point: Encounter Data/Reports

• **Know what is required**

• **Request your data** - You have the right to request your data and peer or other comparisons

• **Reimbursement** - How are they going to use your data for the pricing mechanisms to be discussed

• **Reports** - Request the reports/ know your contractual rights to copies
Quality Care Initiatives

• **Evolving concept** - will be the “guise” for cost control.
• **Buzz words** – “Benchmarks” and “Outcomes”
• **Don’t allow vagueness** – Know exactly what metrics are being measured
• **Be wary** of this being the basis for “medical necessity”
• **Benefit creep** – MCO pushing down State requirements
Penalties

• Mostly a creature of the State Contract and law
• Pass through by the MCO
• Indemnification of MCO for penalties they receive.
• Can include attorney’s fees and investigative costs of the government agency
Electronic Health Records

• **Cost item:** MCO may require your EHR be compatible with their system
• **Disparate systems:** Is there a mandate in the program for use of EHR and interoperability?
• **Security concerns:** Whole new level of HIPAA concerns
• **Stealth Audits:** Review of electronic records for compliance
How do you Contract for what you want

- **Addendums**: MCO Contracts will have required provisions that must comply with State requirements. However, in order to add or modify contract provisions, prepare an addendum that reflects your desired changes to be incorporated as part of the Agreement.

- **Read the Manuals**: They are part of what you have agreed to via the Agreement

- **Know the State Contract** so you are knowledgeable of what is required or not required

- **Develop a relationship**- with your contract provider representative as they can provide assistance and make the relationship a win-win for all.
Additional Thanks!

• We would also like to thank_______ law firm in _____ Florida for their contracting tips.