Managed Care Contracting

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Medicaid Managed Care Programs

- Almost 72% of Medicaid beneficiaries were enrolled in some form of managed care as of 2009.
- Every state except for Alaska, Wyoming, and New Hampshire uses managed care in Medicaid.
- Trends in Medicaid managed care today:
  - Managed care is viewed as cost containment tool as beneficiary population expands and states face budget crises.
  - States expanding Medicaid managed care to cover more fragile populations.
Managed Care: Why Now?

• Affordable Care Act
• Medicaid Expansions
• State Health Insurance Exchanges
Service Delivery Models in Managed Care
Health maintenance organizations (HMOs)

- Provide care to voluntarily enrolled group.
- Provide fixed set of basic and supplemental services.
- Require enrollees to use services of designated providers.
- Specialist services may be accessed only through a referral by the enrollee’s primary care physician (PCP).
Service Delivery Models in Managed Care: HMOs

HMO provider network models

- **Staff model**: HMO directly employs physician staff.
- **Group model**: HMO contracts exclusively with a single provider group.
- **Network model**: HMO contracts with independent practice associations (IPAs), medical groups, or individual physicians.
Preferred Provider Organizations (PPOs)

- Arrangements negotiated between a third-party payer and group of providers.
- Providers offer discounted fees to payor.
- Payor, in return, expects to receive prompt payment and a certain volume of patients.
- Easier for enrollees to access care outside network than under HMO, but cost-sharing is higher than for in-network services.
Many public and private payors provide specialized services through separate plans (sometimes called a **carve-out**).

Common services to provide through carve-out plans are **dental care, prescription drugs, behavioral health services, and vision care**.

Concept behind carve-out plans is that a specialized entity can better handle risk associated with these services.
Provider Reimbursement Methods
Provider Reimbursement Methods: Fee-for-Service

- Provider agrees to a fee schedule (typically, with a different fee for each service).
- Provider submits to MCO a retrospective claim for each service provided.
- High volume of service usage, or usage of costlier services, benefits the provider, since each service is billed separately.
- Revenues increase as more services are provided.
Provider Reimbursement Methods: Fee-for-Service

- Main **advantage** of fee-for-service payment is predictability.
- **Disadvantages** of fee-for-service payment:
  - Burdensome claims submission process
  - Payment disputes arising where MCO determines claim submitted not to be a “clean claim”
  - Provider responsibilities relating to coordination of benefits (identifying third-party payors)
Provider Reimbursement Methods: Capitation

- Provider receives prospective flat payment for each enrollee per month ("per member per month," or PMPM, payment).
- Payment does not vary according to number or nature of services provided.
- Number of enrollees in provider’s panel, rather than the actual utilization of services, dictates payment.
Provider Reimbursement Methods: Capitation

**Advantages** of capitation:

- Non-clinical services, such as case management, can be taken into account in payment.
- Disputes over payment less likely to arise under capitation than under fee-for-service.

**Disadvantages** of capitation:

- Unpredictability
- Capitation may encourage providers to ration treatment in order to contain costs.
Provider Reimbursement Methods: Care Management Fees

- **“Primary care medical home” (PCMH) model**: each patient has a relationship with a PCP who serves as patient’s first contact.
- PCMH programs encourage PCPs to provide care management and other enabling services.
- Recent years have also seen rise in “disease management” programs in which PCP is required to implement plan of care addressing chronic condition.
- A per-member-per-month fee often used by payors or MCOs for care management services when the provider is otherwise paid on fee-for-service basis.
Contract Review Strategies
Managed Care Contract Review Strategies

• A thorough review of the proposed contract between the provider and an MCO, from the business, operational, clinical, and legal perspectives, is essential.

• The three basic steps:
  • Preparation process
  • Contract analysis
  • Negotiation with MCO

• Most MCOs offer a “standard contract”; do not assume that the provider must accept this contract wholesale!
Preparing to Review

• Set a timeframe for review.
• Assemble review team.
  • Establish “point person” and review team lead.
  • Assign areas of contract review to team members based on expertise.
• Assemble documents.
  • Obtain entire proposed contract from MCO, including all referenced and incorporated documents.
  • Obtain other documents necessary to understand legal obligations (for example, in Medicaid managed care, the MCO’s contract with the State).
Preparing to Review

- Considering past performance of the MCO is crucial. If applicable, gather information about past experience of the provider with this MCO:
  - Did the MCO meet its payment obligations on time?
  - Was the number of denied claims excessive?
  - Did the MCO give the provider a role in the development of policies, such as utilization review?
  - Was the MCO responsive to the provider’s requests?
Negotiating the Contract

• Assessing leverage is a key component of a successful negotiation.
  • If the MCO if required by law to include the services in its network, and there are few providers offering those services, then the MCO is more likely to respond positively to proposed contract modifications.
  • The provider should keep in mind (and make sure that the MCO is aware of) its internal strengths and abilities (e.g., ability to deliver cost-effective, quality services promptly and reliably; access to target populations; ability to monitor and control utilization, costs and quality assurance).
  • The provider should also recognize its weaknesses and be prepared to address them in negotiation should they come up.
Negotiating the Contract

• Assessing leverage also includes an evaluation of the MCO’s background and fitness. The provider should examine the following elements of the MCO’s operation:
  • Financial stability and strength
  • Administrative record
  • Operational methods
  • Structural framework
Contract Review
Scope of Services

• MCOs typically contract with a range of providers, each of which furnishes a subset of the full range of services that the MCO is responsible for covering on behalf of the payor.

• The scope of services section of the contract specifies which covered plan services the provider is responsible for providing.
Covered Services

• It is important to distinguish the scope of services included in the provider’s contract with the MCO, from covered services (the services available to the enrollee under the MCO’s plan).

• Sometimes, groups of enrollees have different benefits plans; not every service falling in the provider’s scope of service under the contract is covered under a particular enrollee’s benefit plan.

• The contract should make clear that the provider may treat enrollees as private-pay patients for purposes of providing non-covered services.
How Services Are Provided

- The contract should clearly state any limits on *how* services can be provided by the provider, including:
  - Limitations on which types of clinicians may provide certain services
  - Limitations on the provider’s ability to arrange for services through subcontract
Referral Policies

- The MCO contract will likely contain provisions specifying when and how the provider may make referrals of enrollees to other practitioners.

- The PCP serves as a “gatekeeper,” determining enrollees’ access to specialty services; MCO constraints on referrals can negatively impact service delivery.
Gag Clauses

• A gag clause is a contract provision that limits the PCP’s or other clinician’s ability to advise patients of all medically appropriate treatment options.

• Some gag clauses are based on moral and religious considerations prohibit the provider from counseling patients on services to which the MCO objects (e.g., abortion, contraceptive methods).
Access Standards

- These standards define the required level and availability of care from a patient-centered perspective.
- Access standards in managed care contracts commonly address:
  - Required hours and days of operation and coverage (including evening and weekend business hours)
  - After-hours coverage and on-call coverage when a designated health care professional is unavailable
  - Maximum waiting times for establishing an appointment for various categories of services
  - Required intervals for providing specific services, such as well child checkups
  - Maximum waiting-room times
Enrollee Change of Providers

- While most contracts contain provisions dealing with enrollment into and disenrollment from the managed care plan, some fail to address the need for a procedure to handle the transfer of an enrollee to another primary care provider (PCP) within the MCO.

- Some of the reasons you may want to transfer an enrollee include:
  - Behavior of an enrollee (e.g., disruptive, unruly, abusive or uncooperative)
  - Any other reason which impairs the provider's ability to furnish services to either that Enrollee or other Enrollees
“Clean Claim” Rules

- Contracts with fee-for-service reimbursement typically make payment contingent on the filing of a **clean claim**.
  - “Clean claim” is a claim that can be processed by the MCO without requesting any additional information from the provider or a third party.

- The contract should clearly define “clean claim,” and attach approved forms and an instructional manual.

- Providers should be wary of provisions giving the MCO the right to “re-bundle” codes or otherwise modify submitted claims according to the MCO’s payment protocols, in order to make the claim conform to “clean claim” standards.
MCO Timely Claiming Rules

- The contract should allow a sufficiently long window for the provider’s submission of claims to the MCO (at least 60 days).

- Providers should check the proposed contract for provisions concerning the consequences of late claim submission.

- The provider should negotiate for a provision that makes MCO denial of late claims discretionary rather than mandatory.
Prompt Payment Rules

• Just as the MCO has an interest in timely claims submission, the provider has an interest in timely payment!

➢ The contract should include a prompt payment provision.
  ▪ In fee-for-service contracts, number of days from submission of claim (30 to 45 days is typical)
  ▪ In capitation contracts, fixed date for prospective PMPM payment (typically by 5th day of month that the payment covers)

➢ The contract should impose interest on the MCO for late payments to the provider.
Correction of Overpayments and Underpayments

• MCO contracts typically allow the MCO to recoup overpayments (excess payment by the MCO to the provider).

• Contracts commonly permit the MCO to recoup an overpayment by offset; the MCO subtracts the overpayment from any amounts due to the provider.

➢ The contract should not allow such an offset until the MCO has given the provider notice of the alleged overpayment and afforded the provider an opportunity to appeal the determination.

➢ The contract should also permit the provider to dispute underpayments.
Dispute Resolution Process

- The contract should contain a streamlined, expedited process for **claims disputes**, and a more elaborate process for other disputes.

- The contract should use a **graduated, step-by-step** dispute resolution process.
  - Informal negotiation
  - Mediation
  - Arbitration (binding or non-binding)

- The contract should **not** require the provider to exhaust an appeals process within the MCO before resorting to other measures.
Term

• Contracts generally state how long the contract will be in force (term) and the procedures for renewing or terminating the contract.

• When initially contracting with an MCO, the provider may want to limit the term of the contract to one year without automatic renewal (“evergreen”) provisions.
Termination

- Contracts can typically be terminated “for cause” or “without cause”.
- The situations that constitute cause are generally breaches of **material terms** of the contract.
- Typically either party may terminate with or without cause after providing **notice to the other party** (e.g., 30 days’ notice in terminations for cause; 60 days’ notice in terminations without cause).
Breach and Cure

- Breaches (violation of the terms of the contract) sometimes lead to termination of the contract, but not always.
- The contract should give the breaching party an opportunity to “cure” (fix) most breaches before termination is triggered.
Renewal

- In most contracts favorable to providers, renewal of the agreement is contingent on mutual agreement as to payment terms for the subsequent term.

- The contract should specify how quickly renegotiation of payment terms must occur after one party notifies the other party of its desire to renegotiate, with a deadline for a decision.
Amendments

- Amendment provisions are particularly crucial in MCO contracts, because the clinical, operational, and financial environments in which the parties operate are subject to constant change.

  ➢ The contract should guarantee the provider’s right to **review any and all changes** to the contract.

  ➢ The contract should provide that no changes shall take effect until and unless the provider has given prior written approval.
Other Legal Provisions

- Patient Cost-Sharing
- Third Party Liability / Coordination of Benefits
- Indemnification
- Insurance
- All-Product Clauses
- Non-Discrimination Clauses
- Licensing
- Credentialing
- Utilization Management/Review
Negotiating the Contract

- Because of antitrust concerns, providers **may not negotiate together** as a group with MCOs.

- Providers must generally make **independent, unilateral decisions** on whether to accept contractual terms.
Negotiating Strategies

• It is not enough to simply present your terms and proposed modifications to the MCO.
• Instead, the provider should develop an individualized negotiation strategy, including the following:
  • A list of the provider’s objectives and priorities for the contract
  • Development of a list of deal points / critical elements for negotiation
  • Formation of the framework for negotiations using the objectives, priorities, and deal points
  • Establishment of a bottom line for withdrawal – when do you say “no”
Negotiating Strategies

- A common error is bargaining over positions.
  - Occurs when one or both parties get stuck in ensuring that they win on their positions, regardless of whether the overall goal is attained.
  - Parties take extreme positions in the expectation that they will have room to bargain down.
  - Results in a loss of focus on underlying concerns.
Negotiating Strategies

- Instead, focus on underlying interests:
  - Respond with questions, rather than statements, and respond specifically to the MCO’s concerns.
  - Develop options for mutual gain and generate a variety of possibilities before deciding what to do.
  - Look for zones of agreement and areas of overlap, emphasizing the importance of maintaining an ongoing relationship.
  - Insist that resulting provisions be based on some objective standard.
When to Walk Away

• Set a “bottom line” based on factors including:
  • The importance of the MCO contract to the provider’s operation
  • The extent to which the contract embodies the provider’s goals and objectives
• It may be best to walk away if the provider does not trust the MCO or if the two are not a good “fit”.
• The provider must walk away from any contract that does not pass legal muster in its final form (for example, it includes provisions that are inconsistent with or contrary to specific legal requirements).
Questions?

Use the **Q&A menu option** at the top of the webinar window. Click the **ASK** button to submit your questions.

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