



The Managed Care Technical Assistance Center
EFFICIENT PRACTICES. EFFECTIVE CARE.

Medicaid Managed Care Contracting Workshop Series for New York State Behavioral Health Agencies

Workshop Overview & Anatomy of a Contract

Presented by:

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Dan Ferris, MPA, NYU McSilver Institute, MCTAC

MCTAC Overview

What is MCTAC?

MCTAC is a training, consultation, and educational resource center that offers resources to all mental health and substance use disorder providers in New York State.

MCTAC's Goal

Provide training and intensive support on quality improvement strategies, including business, organizational and clinical practices to achieve the overall goal of preparing and assisting providers with the transition to Medicaid Managed Care.

MCTAC Overview (cont.)

- MCTAC is partnering with OASAS and OMH to provide:
 - Foundational information to prepare providers for Managed Care
 - Support and capacity building for providers
 - tools
 - informational training & group consultation
 - assessment measures
 - Information on the critical domain areas necessary for Managed Care readiness
 - Aggregate feedback to providers and state authorities

Who is MCTAC?

McSilver Institute
for Poverty Policy and Research
NYU SILVER SCHOOL OF SOCIAL WORK



People Get Better With Us



Previous Contracting Trainings

In-person contracting sessions (618 attendees)

- November 14: Rochester
- November 25: Long Island
- December 9: Manhattan
- December 10: Albany
- January 13: Manhattan

93% of feedback form respondents found the in-person contracting session with Adam Falcone useful.

- MCTAC/Coalition Contracting Fair 5/26

Web-based offerings:

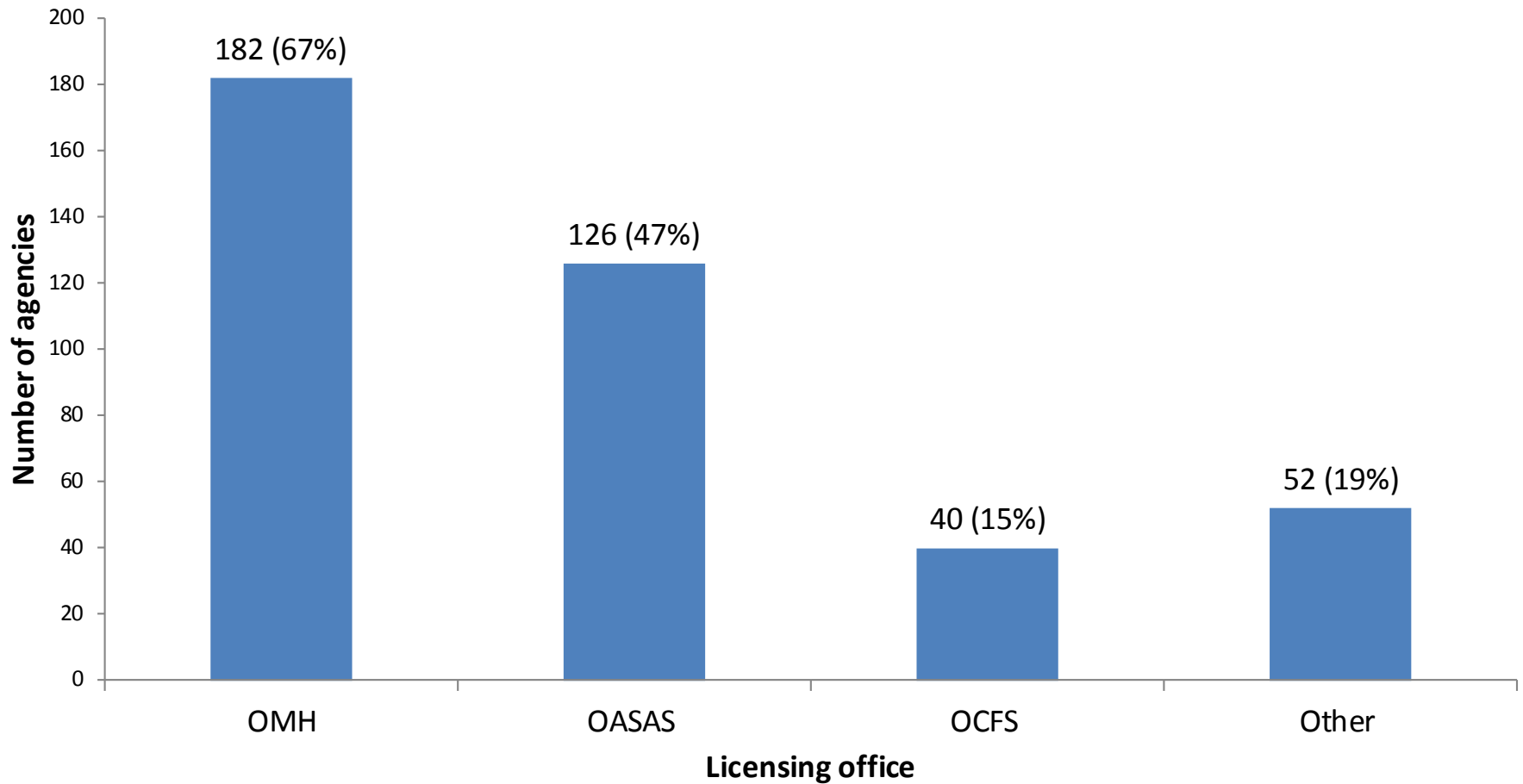
- December 17: Managed Care Contracting: The Plan Perspective, featuring Harold Iselin and Whitney Phelps of Greenberg Traurig
- February 10: Contracting Overview and Office Hours with Adam Falcone
- March 25: Managed Care Contracting: The Provider Perspective, featuring Ron Lampert and Mark Furlong, Thresholds

Contracting Readiness Assessment

	Not Ready	Somewhat Ready	Moderately Ready	Mostly Ready	Definitely Ready
Rate your organization's capability to understand the requirements of the managed care contracts you have.	47 (14%)	57 (17%)	96 (28%)	84 (24%)	82 (11%)
Rate your organization's capability of assessing compliance with the requirements of the managed care contract you have.	50 (15%)	61 (18%)	89 (26%)	86 (25%)	57 (17%)
Rate your fiscal staff's capability of assisting with pricing issues during contract negotiations	63 (18%)	69 (20%)	86 (25%)	61 (18%)	66 (19%)
Rate your fiscal staff's ability to readily compare actual to anticipated revenue and expense by contract.	50 (9%)	62 (18%)	73 (21%)	85 (25%)	73 (21%)
Rate your organization's understanding of CMS compliant codes that will be used for billing	70 (20%)	47 (14%)	75 (22%)	76 (22%)	78 (14%)

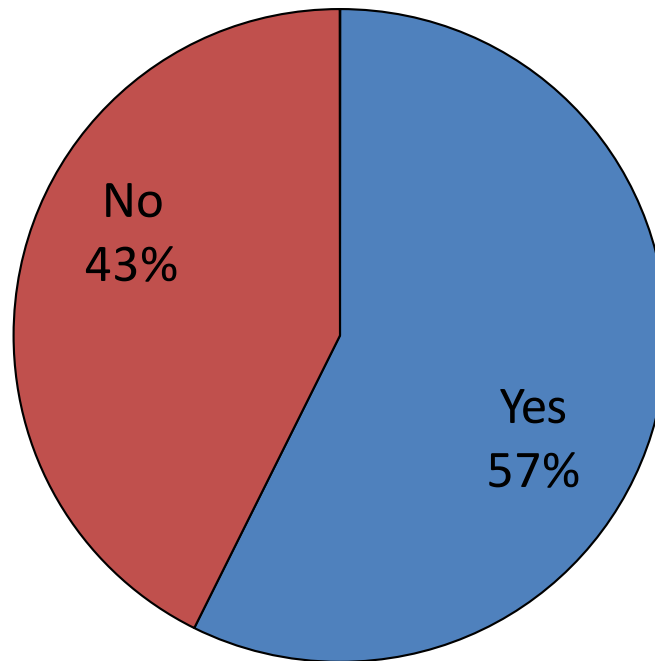
Contracting Workshop Participants

By whom is your agency licensed?



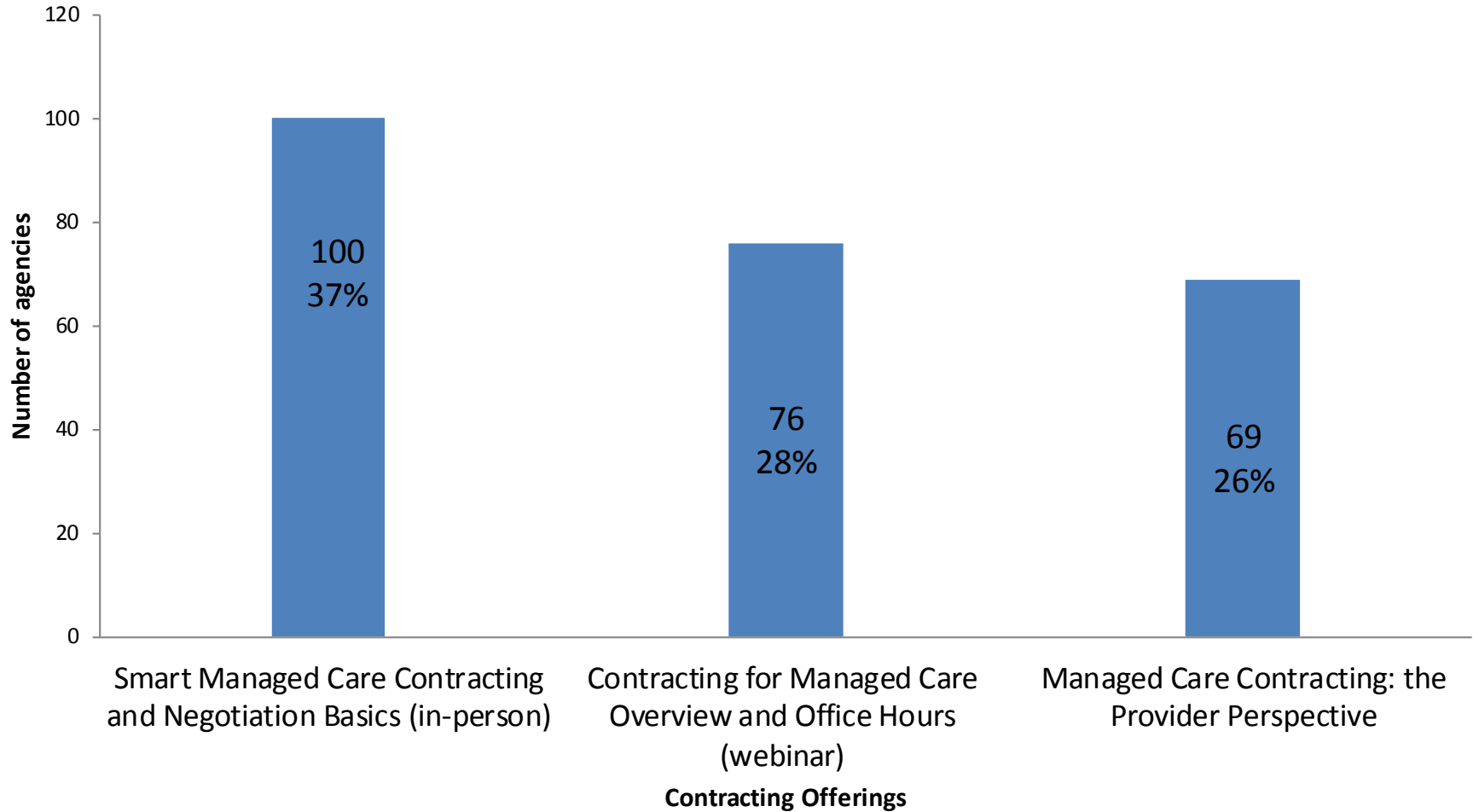
Contracting Workshop Participants

Does your agency have contracts in place with the respective MCOs?



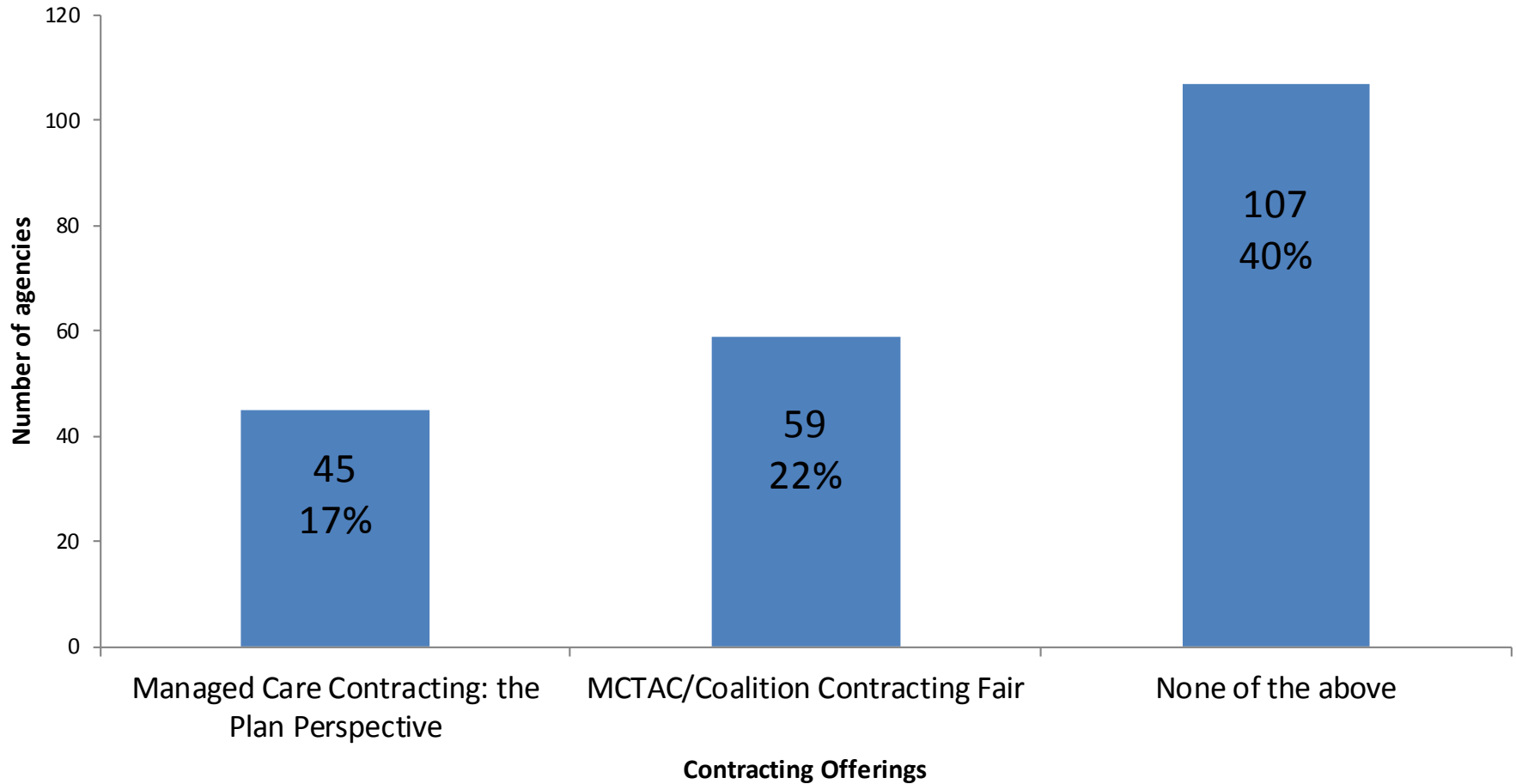
Contracting Workshop Participants

Has a representative from your agency attended a MCTAC Contracting offering?



Contracting Workshop Participants

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Workshop Outline

- Anatomy of a Contract & Team-Based Assignment (6/17)
 - Participants review assignment and sample contract
 - Send questions to MCTAC.info@nyu.edu with subject line “Contracting Workshop Assignment” ahead of...
- Office Hour (save-the-date): July 8, 12:30 – 1:30 PM
- Participants finish assignment and submit responses using qualtrics survey link by 5 pm on Monday, July 20th.
- Wrap-Up with Assignment Review (save-the-date): July 30, 11 AM – 12 PM

MCTAC suggests: reviewing slides/recordings of kickoff series and Adam’s initial training

Sponsored by the New York State
Medicaid Managed Care Technical Assistance Center (MCTAC)

Anatomy of a Managed Care Contract



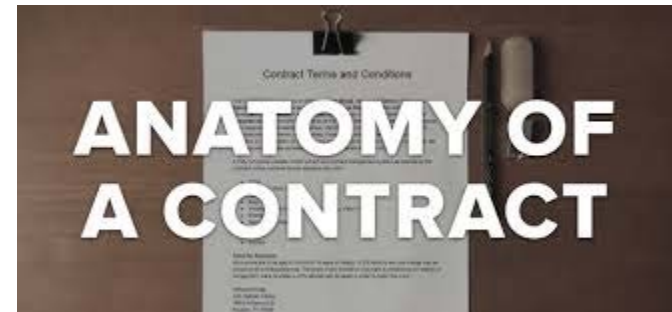
Adam J. Falcone, J.D., M.P.H.
Partner
Feldesman Tucker Leifer Fidell LLP

DISCLAIMER: EDUCATIONAL ONLY

This training is provided for general informational and educational purposes only and does not constitute legal advice or opinions. The information is not intended to create, and the receipt does not constitute, an attorney-client relationship between trainer and participant. For legal advice, you should consult an attorney.

FOUR PARTS OF THE CONTRACT

1. Header / Recitals
 - “Back Story”
2. Contract Provisions
 - “Meat and Potatoes”
3. Exhibits
 - “Moving Pieces”
4. Referenced Documents
 - “Hidden Terms”



HEADER / RECITALS

- Parties to the Agreement
 - Should identify correct legal names of parties
 - Should identify type of legal entity (e.g., non-profit, for-profit, LLC) and mailing address
- Effective Date
 - Generally, should have prospective start date
- Recitals
 - Should explain purpose of contract (or contract's amendment)



TYPICAL ORDER OF CONTRACTUAL PROVISIONS

1. Definitions
2. Provider Obligations
3. Payor Obligations
4. Compensation and Billing
5. Insurance
6. Indemnification
7. Records and Confidentiality
8. Dispute Resolution
9. Term and Termination
10. Miscellaneous



COMMONLY DEFINED TERMS

- Clean Claim
- Covered Services
- Emergency Services
- Medically Necessary
- Member
- Participating Provider
- Product
- Provider
- Provider Manual
- Quality Assurance Program
- Utilization Review Program

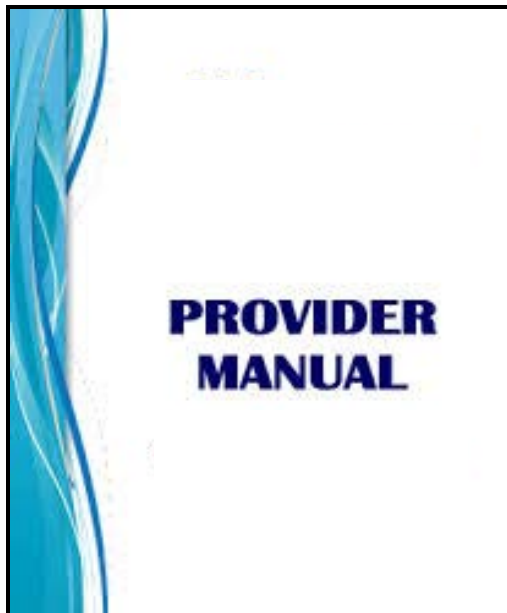


COVERED SERVICES



- 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.
 - If provider is not certain what services are covered, then provider should request copy of covered services from Plan.
 - The contract should make clear that the provider may treat enrollees as private-pay patients for purposes of providing non-covered services.

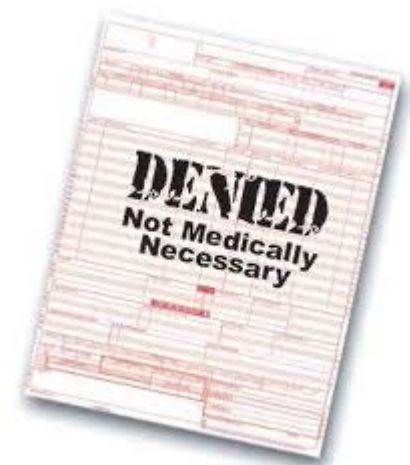
PROVIDER MANUAL



- Typically describes Plan's process for:
 - Verification of member eligibility
 - Credentialing
 - Prior authorizations / utilization management
 - Claims submission and appeals
- During contract review, should be able to review provider manual upon request.
- Changes to provider manual should only be allowed when provider has adequate notice **in advance** of the effective date of change to reasonably achieve compliance.

MEDICAL NECESSITY

- Medical necessity is typically defined as a determination made by the Plan using generally accepted practice standards.
- Under Section 3.9 of the RFQ, Plans must comply with NYS Medicaid medical necessity standards in making prior authorization, concurrent or retrospective review decisions affecting individuals covered by Medicaid.
- Accordingly, the provider agreement should expressly require Plans to use OMH/OASAS standards for determining medical necessity for Medicaid beneficiaries.



PROVIDER OBLIGATIONS



- Scope of Services
- Eligibility Verification
- Licensure and Certification
- Standard of Care
- Non-Discrimination
- Credentialing
- Quality Assurance
- Utilization Management

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 Services the provider is responsible for providing, which may refer to a contract exhibit.
- The scope of services should be broad enough to encompass all of the services furnished by the provider but no more.



Scope of work

“ALL PRODUCTS” CLAUSES

- MCOs have different lines of business, known as “products”, (e.g., HMO, PPO, commercial exchange, commercial group, Medicare Advantage, Medicaid), each with different fee schedules.
- An “all-products” clause requires the provider to participate in all products, with applicable fee schedules, offered by the MCO currently and *prospectively*, without an opportunity to negotiate adequate reimbursement rates or “opt-out”.
- NYS announced that MCOs will not be allowed to include “all-products” clauses in contracts with behavioral health providers, though providers may still agree to participate in other products.
- Until NYS formally amends MCO contracts to prohibit “all-products” clauses, providers should seek the right to participate in products individually and the right to negotiate reimbursement rates in each new product offered by the MCO in the future.



LICENSURE AND VERIFICATION

- Generally, provider warrants that:
 - it has all applicable licenses and certifications required by law to furnish services;
 - any employees furnishing services are properly licensed or certified to furnish services;
 - It will notify Plan immediately in the event it loses accreditation, licensing or certification
- Notification to Plan, when required by the contract, should always occur after the government completes its investigation and makes formal findings against the provider or practitioner.
- Provider should ensure provision does not require notification when Provider is under nothing more than an investigation by government entity, that Provider's employee is under investigation by licensing agency, or mere allegations are made against provider.



PLAN OBLIGATIONS

- Plan Administration
 - Marketing
 - Enrollment and Identification Cards
 - Claims Processing and Payment
 - Utilization Review
 - Quality Assurance
 - Case/Care management
 - Credentialing
 - Grievance/Appeals

BILLING AND COMPENSATION

- Compensation
- Billing Procedures
- Claims Payment
- Coordination of Benefits
- Recoupments of Overpayments



CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES

- Managed care contracts do not generally permit a provider to reduce the amount of cost-sharing owed by an enrollee.



- Providers should be aware that a routine practice of discounting or waiving these obligations for all patients should be avoided, as it opens the provider up to potential liability on numerous fronts.
- If provider has a charity care policy that applies to insured patients, then provider should seek language that permits it to waive or reduce the amount of cost-sharing for enrollees of the Health Plan.

TIMELY CLAIMS FILING



- The contract should allow a 90-day window for the provider's submission of claims to the MCO
- 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 in case there is good cause that a timely claims filing deadline is missed.

PROMPT PAYMENT



- Just as the MCO has an interest in timely claims submission, a provider has an interest in timely payment.
- New York's Prompt Payment Law provides:
 - 30 day processing of clean electronic claims
 - Written notice of reason for denied claims
 - MCO pays 12% interest for late payments
- The contract should incorporate the prompt payment statute, not simply provide the citation, so that the legal requirements are understood by both parties.

PAYMENT SUSPENSIONS AND REDUCTIONS

- The contract may allow the Plan to suspend all payments to provider at the direction of the Medicaid agency, or reduce payments to provider if the Medicaid agency reduces payments to Plan, all without obtaining the provider's consent.
- Despite the Plan's payment suspension or reduction, Providers remain obligated to continue rendering services to Plan's enrollees, which may place the provider in financial jeopardy.
- Providers should seek to remove this provision, or alternatively, seek modification of the provision so that the payment suspension or modification is grounds for immediate termination of the agreement.



RETROACTIVE DISENROLLMENT

- For various reasons, individuals may be **retroactively** disenrolled from a Plan despite a Provider verifying eligibility on the date services were furnished to an enrollee.
- As a result of the individual no longer considered a “Covered Person” at the time services were furnished, the services will not be eligible for payment by the Plan.
- Plan will retroactively deny payment, determining that a provider has received an overpayment, depriving provider of payment for services it was obligated to furnish to enrollee at the time.
- To avoid financial risk for circumstances outside of provider’s control, the contract should make Plan financially liable for services furnished to individuals who are later retroactively disenrolled.



CORRECTION OF OVERPAYMENTS (& UNDERPAYMENTS!)

- MCO contracts typically allow the MCO to recoup **overpayments** (excess payment by the MCO to the provider) within a specified period, usually within one or two years of payment by the Plan.
- Contracts commonly permit the MCO to recoup an overpayment by **offset**; the MCO subtracts the overpayment from any amounts due to the provider.
- Consistent with NYS Insurance Law, the contract **should not allow** such an offset until the MCO has given the provider notice of the alleged overpayment, proposed adjustment, reasonably specific explanation, and afforded the provider an opportunity to appeal the determination.
- The contract should also permit the provider to dispute **underpayments** within the same period of time that the Plan has the ability to recoup overpayments.



REGULATORY PENALTY PROVISIONS

- From time to time, a regulatory agency may assess a fine or penalty against an MCO for failing to meet its contractual requirements with the Medicaid agency.
- Under “regulatory penalty provisions”, a provider agrees to be liable for a share of the penalty imposed on the MCO if the provider’s action or inaction contributed to the penalty.
- Frequently, a provider’s actions or inactions are neither willful or negligent. However, providers do not have authority to appeal or dispute the regulatory agency’s fines or penalties against the MCO.
- Providers should seek to remove regulatory penalty provisions from the contract so that it is liable only to the extent that provider has agreed to indemnify Plan, pursuant to the indemnification terms of the contract.



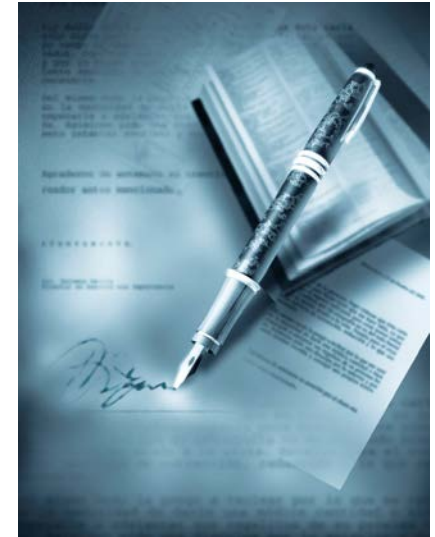
MCO INSURANCE COVERAGE



- The contract will require the provider to maintain various forms of insurance coverage.
- The MCO should be contractually required to obtain reinsurance to cover the cost of excess losses due to unusually large claims related to a single enrollee.
- This promotes the Plan's solvency and therefore increases the likelihood that the provider will be paid.

INDEMNIFICATION

- Indemnification provisions state which party to a contract bears the risk (and liability) for certain tort (negligence) claims brought by third parties.
- A party is “indemnified” if, by virtue of a contract provision, it avoids assuming responsibility for another party’s wrongful acts or omissions arising out of performance of the contract.
- Many contracts only require the provider to indemnify the Plan. However, indemnification clauses should protect both parties of the risk of claims by third parties.
- The contract should require the Plan to indemnify provider for any claims against the provider that were caused by the Plan’s wrongful actions or inactions under the Agreement.



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

- Enrollees/providers may file a complaint regarding managed care plans to DOH: **1-800-206-8125** or managedcarecomplaint@health.ny.gov. Regional Planning Consortia (RPCs) will work closely with State agencies to guide behavioral health policy and problem solve service delivery challenges.

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 an automatic renewal (“evergreen”) provision.
- Without automatic renewal, the parties will be required to enter a new agreement for a subsequent period, giving each the opportunity to re-negotiate problematic terms or decide not to contract with each other.



TERMINATIONS

Contracts can typically be terminated by mutual agreement as well as by one party “**for cause**” or “**without cause**”

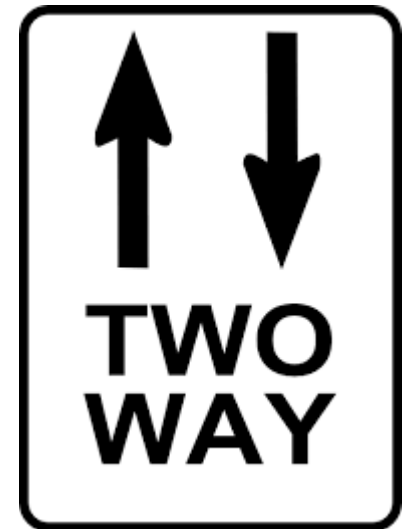
The situations that constitute cause are generally breaches of **material terms** of the contract

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)



TERMINATION FOR CAUSE

- Contracts typically permit the Plan to terminate the contract for cause, such as:
 - Imminent harm to patients
 - Provider's loss of licensure or eligibility for participation in Medicaid or Medicare
 - Provider's loss of insurance
 - Provider's insolvency or commencement of bankruptcy or insolvency proceedings
 - Material breach of the terms of the contract (and failure to cure within 30 days)
- Because similar events may jeopardize Plan's continued ability to pay for services, provider should seek right to terminate the contract for cause, such as.
 - Plan's loss of licensure or eligibility for participation in Medicaid or Medicare
 - Plan's loss of insurance
 - Plan's insolvency or commencement of bankruptcy or insolvency proceedings
 - Material breach of the terms of the contract (and failure to cure within 30 days)



TERMINATION WITHOUT CAUSE



- Contracts frequently permit a party to terminate the contract without cause, which means that the party seeking termination does not need to have a reason to terminate the contract.
- Termination without cause is effective after any required notice period has been given to the other party.
- Because neither party requires cause, the notice period effectively becomes the “term” of the contract, meaning that either party can get out of the contract quickly.
- Providers should consider whether it would benefit from the addition or deletion of a “termination without cause” provision.

POST-TERMINATION OBLIGATIONS

- Following termination of the contract, providers typically remain obligated to continue to provide services to Plan's enrollees for a defined period of time or until the Plan transfers care to another provider in Plan's network.
- Provider should ensure the contract makes clear that Plan is required to pay provider at rates then in effect for any covered services it is obligated to render after termination of the contract.
- Nothing should bar provider from communicating with Plan's enrollees following termination of the contract, as many will have questions on how to access services.



ASSIGNMENT

- Plans typically have the right assign the contract to another party without the provider's consent.
- If assignment rights are invoked, it may result in provider participating in the network of a different MCO, though under the same terms as the Provider had agreed to previously.
- Provider should consider whether it would benefit from having the right to consent to the assignment, or alternatively, the right to terminate the contract upon assignment by the Plan.



AMENDMENTS

- Contracts typically allow the parties to define the terms in which either party may amend the contract.
- Amendments that do not require a party's consent allows the other party to change the substantive terms of the agreement.
- The contract should guarantee the provider a period of time (e.g., 30 days) to review any and all changes to the contract prior to taking effect.
- The contract should provide that no changes shall take effect if the provider objects to the amendment, in which case the contract should continue under the original terms.



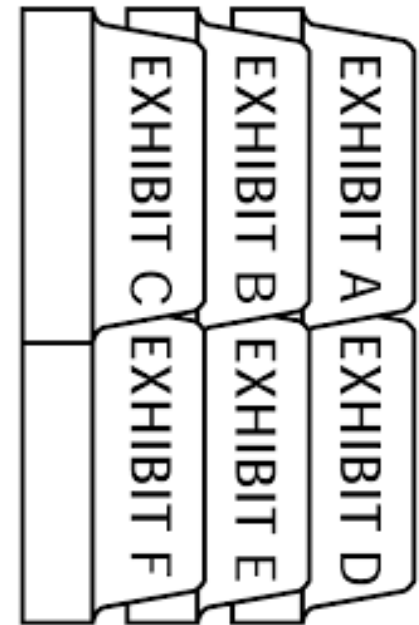
NOTICE



- The notice clause describes how communications must be made by the parties under the contract to have legal effect.
- Notice clauses typically describe the:
 - Means of communication, e.g., written notice
 - Mode of delivery, e.g., courier service, certified postal service, electronic delivery
 - Name of recipient (or recipients) and their address.
- It is essential that the notice clause contains the correct name and title of the individual who should receive official notices under the contract.

EXHIBITS

- Exhibits often contain the most significant terms of the contract between Plan and provider. These include:
 - Covered Services
 - Locations / Practitioners
 - Products
 - Fee Schedules
- Providers should closely review the exhibits and ensure that the meaning and implications of terms are well understood.
- Providers should request the Plan to clarify any confusing or ambiguous terms that may appear; this can avoid disputes in the future.



REMINDER: WORKSHOP OUTLINE

- Anatomy of a Contract & Team-Based Assignment (6/17)
 - Participants review assignment and sample contract
 - Send questions to MCTAC.info@nyu.edu with subject line “Contracting Workshop Assignment” ahead of...
- Office Hour (save-the-date): July 8, 12:30 – 1:30 PM
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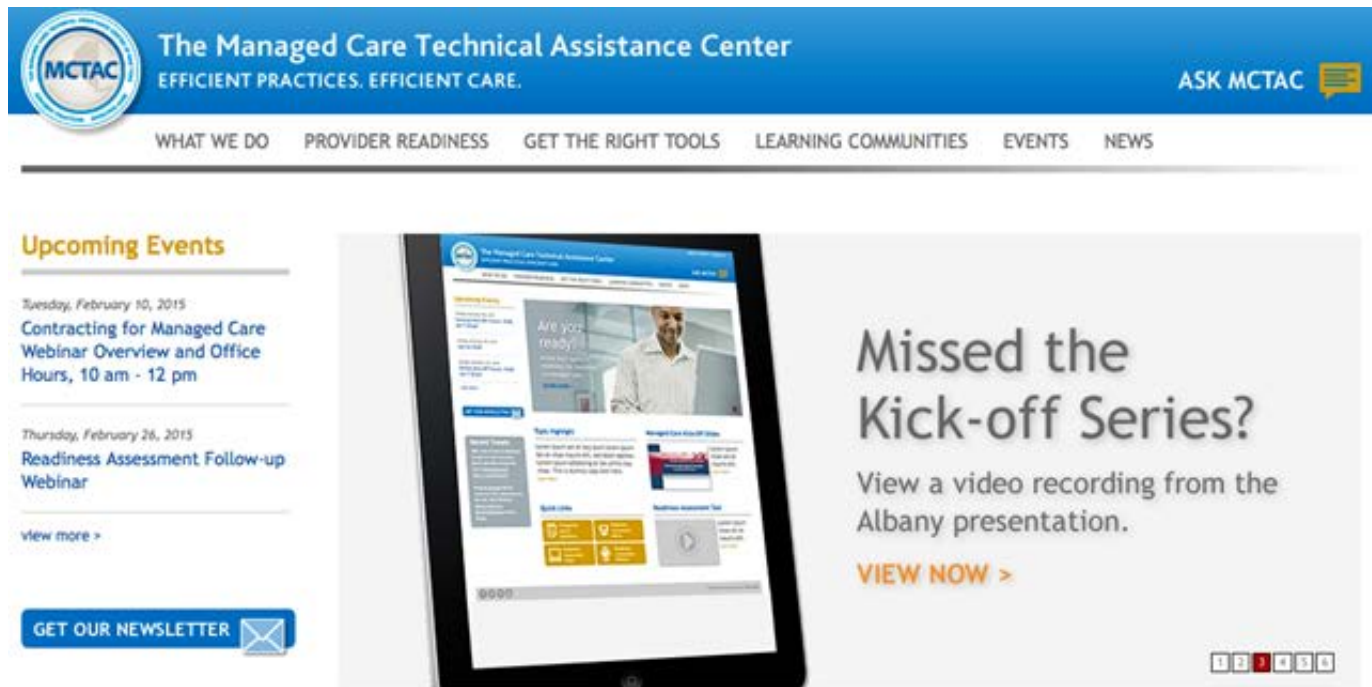
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Thank you very much for your participation!

Visit www.mctac.org to view past trainings, sign-up for upcoming events, and access tools & resources.



The screenshot shows the MCTAC website header with the logo and tagline "The Managed Care Technical Assistance Center EFFICIENT PRACTICES. EFFICIENT CARE." and a navigation menu including "WHAT WE DO", "PROVIDER READINESS", "GET THE RIGHT TOOLS", "LEARNING COMMUNITIES", "EVENTS", and "NEWS". Below the header, the "Upcoming Events" section lists two events: "Contracting for Managed Care Webinar Overview and Office Hours, 10 am - 12 pm" on Tuesday, February 10, 2015, and "Readiness Assessment Follow-up Webinar" on Thursday, February 26, 2015. A "GET OUR NEWSLETTER" button is also visible. To the right, a banner for "Missed the Kick-off Series?" offers a video recording from the Albany presentation, with a "VIEW NOW >" link.

mctac.info@nyu.edu

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