The Managed Care Technical Assistance Center

EFFICIENT PRACTICES. EFFECTIVE CARE.

Managed Care Contracting – The Plan Perspective

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Managed Care Technical Assistance Center 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

Managed Care Technical Assistance Center

MCTAC will offer:

- Foundational information to prepare for Managed Care
- Support and capacity building for providers
  - tools
  - consultation
  - informational forums
  - assessment tools
- Critical information along each of the domain areas necessary for Managed Care readiness
- Feedback to providers and state authorities on readiness for Managed Care.
- MCTAC will serve as a clearing house for other Managed Care technical assistance efforts

What Providers Can Do to Make the Most of MCTAC Supports

- Designate a project team including:
  - Executive leadership, Finance & Clinic leadership, and Evaluation staff when available
- Complete the readiness assessment and participate actively in MCTAC activities
- Commit to investing the time and effort needed to assess, diagnosis, improve, and monitor your organization's operations, business practices, and financial performance

MCTAC Contracting Unit

- Five in-person T.A. events:
  - Rochester 11/14
  - Long Island 11/25
  - New York City 12/9
  - Albany 12/10 – Will be recorded and posted on-line
  - NYC TBD (Jan 2015)
- Web-Based Content Series:
  - ***Plan Perspective feat. Harold Iselin & Whitney Phelps (Greenberg Traurig, LLP) 12/17, 2:30 PM.***
  - Provider & Policy Perspective January 2015
  - Contracting Forum Summary and "Office Hours" January 2015
- What's next: Finance & billing, utilization management, measuring and improving outcomes, and more.

Questions or Feedback?

Contact us: MCTAC.info@nyu.edu

Visit MCTAC's website for more information and access to past webinars and trainings: http://www.MCTAC.org

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Overview

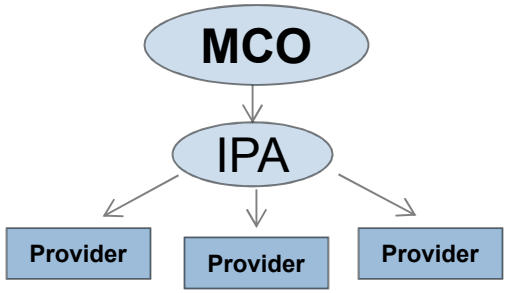
- **Provider Contracts**
  - IPA Contracts
- **Management Contracts**
- **Administrative Contracts**

Overview (Cont.)
Provider Contracts

- **A Provider Contract is an agreement related to the provision of health care services between a provider or IPA and a Managed Care Organization ("MCO"), which is subject to NYS Department of Health ("DOH") regulations and guidelines**
  - The Medicaid Model Contract between MCOs and DOH states that all medical care and/or services covered under the benefit plan must be provided through a provider agreement with participating providers, except for emergency, family planning and self-referral services
- **The services rendered under a Provider Contract should reflect the scope of services of the provider entering into the contract that are also covered services under the benefit plan:**
  - Special behavioral health service providers
  - Entities licensed under Article 28 of the PHL or Articles 31 or 32 of the MHL
  - Individual practitioners, such as psychiatrists, psychologists, social workers

Overview (Cont.)
IPA Contracts

- **An Independent Practice Association ("IPA") is a corporation or LLC that contracts with providers of medical or medically related services in order that it may then contract with one or more MCOs to make the services of all the providers available to the MCO enrollees.**



  - An IPA is an intermediary that arranges for the provision of services covered under an MCO's benefit plan.
  - Proposed regulations regarding Accountable Care Organizations (ACOs) allow IPAs to be ACOs and to be part of a DSRIP Performing Provider System

Overview (Cont.)
IPA Contracts

- **IPA Pros and Cons**
  - IPA's facilitate network development and access
    - Single signature authority
  - But IPAs are not unions or guilds
    - Antitrust concerns related to collective negotiation
  - IPAs are usually entities that share risk
  - IPAs can provide limited other services to providers who participate in the IPA
  - Approval of the IPA is required by the Department of Health, Department of Financial Services and State Education Department

Overview (Cont.)
Management Contracts

- **A management contract is an agreement between an MCO and a Management Service Organization ("MSO") under which the MCO delegates certain management functions (defined in 10 NYCRR 98-1.11) to the MSO**
- **Management functions are elements of an MCO governing body's management authority**
- **Examples of services rendered by an MSO under a Management Contract, include:**
  - Claims payment
  - Utilization review
  - Quality assurance and improvement
- **Some management functions *must not* be delegated and others *may be* delegated, but only pursuant to a management contract approved by DOH**

Overview (Cont.)
Administrative Contracts

- **Technical and administrative agreements are for services and functions that are <u>not</u>:**
  - the provision of medical care or services covered under the benefit plan or
  - a management function
- **Include administrative expenses that the MCO reports on its cost report**
- **Technically not subject to DOH review and approval**
- **Except for:**
  - health homes
  - consumer directed personal assistance programs
  - transportation
  - some care management services

Provider Contracts

- Key Terms
- Regulatory Provisions
- Contractual obligations imposed on Medicaid Managed Care Organizations that affect providers
- Compensation
- Regulatory Review Process

Provider Contracts (Cont.)
Key Terms

- Parties and Definitions
- Scope of Services and Access to Services
- Payment Adjustments
- MCO Administrative Requirements (i.e. timely filing)
- Insurance
- Indemnification
- Compliance with all laws and Medicaid Model Contract
- Term and Termination
- Representations and Warranties
- Assignment
- Amendment
- Notices
- Dispute resolution or litigation
- Audits, monitoring and oversight

Provider Contracts (Cont.)
Key Terms

- **The Parties**
  - Need to know the legal entities and legal names of the entities entering into the contract
  - Performing Provider Systems (PPSs), IPAs and ACOs
  - Multiple providers with different corporate entities but under a common parent
- **Definitions**
  - Clarify the meaning of key terms
  - Medical Necessity – defined in Medicaid Model Contract

Provider Contracts (Cont.)
Key Terms

- **Scope of Services and Access to Services**
  - What services are being contracted?
  - Payment must be tied to the contracted services that are covered services under the MCO benefit plan
  - Access standards – e.g., appointment availability - must at a minimum meet regulatory requirements
- **Payment Adjustments**
  - Need to agree upon how these activities will be handled (for example, the timeframe and notice requirements and payment implications)
    - Retroactive enrollments
    - Recoupments

Provider Contracts (Cont.)
Key Terms

- **MCO Administrative Requirements - Providers must comply with MCOs' policies and procedures (quality management program, utilization management, authorization and referral requirements), but can also agree to contractual provisions, such as:**
  - Timely filing of claims
  - Adjustments to payments
  - Claim disputes and dispute resolution
- **Insurance**
  - MCOs will require providers to have malpractice insurance and general liability insurance
  - Provider should understand its insurance limits and policy restrictions (Is contractual indemnification allowed?)

Provider Contracts (Cont.)
Key Terms

- **Indemnification and Liability**
  - Contractual indemnification - mutuality
  - An MCO can't transfer liability for its own acts onto a health care provider
  - Joint and several liability
- **Compliance with all applicable state and federal laws and the Medicaid Model Contract**
  - HIPAA
  - Fraud, waste and abuse laws
  - State laws regarding the business of insurance and provision of health care services
  - Medicaid and Medicare laws

Provider Contracts (Cont.)
Key Terms

- **Term and Termination**
  - Automatic renewal or defined contract term
  - "For cause" versus "without cause" termination
    - Standard for material breach
  - Length of notice for termination and non-renewal
  - Due process rights
- **Representations and Warranties**
  - Valid corporation and properly licensed, certified or designated by DOH, OMH or OASIS (licensure obligations can also apply to employees of the provider)
  - Legally binding and enforceable
  - Neither provider nor employees have been suspended or terminated from a federal health care program or convicted of a criminal offense related to Medicaid or Medicare

Provider Contracts (Cont.)
Key Terms

- **Amendment**
  - Mutual agreement, automatic or upon 30 days' notice without objection
  - Changes due to regulatory requirements
- **Assignment**
  - On notice or with consent
  - Change of control
- **Notice to MCO in the event the provider has:**
  - Any lapse, revocation, termination or suspension of license
  - Any lapse, revocation or cancellation of insurance
  - A disciplinary action initiated by a government agency
  - Excluded, suspended, debarred or sanctioned from a federal program
  - A grievance or legal action filed by an enrollee against the provider
  - An investigation, conviction or plea for fraud, a felony, or a misdemeanor

Provider Contracts (Cont.)
Key Terms

- **Dispute Resolution / Litigation**
  - Claim disputes vs. other disputes
  - Venue and choice of law
  - Internal dispute resolution mechanism
    - Timeframe for resolution
    - Identify key management titles with the authority to resolve disputes
  - Alternative dispute resolution or mediation
    - Binding or non-binding
    - American Arbitration Association, American Health Lawyers Association, etc.
- **MCO's have a right to monitor and audit its participating providers**

Provider Contracts (Cont.) Regulatory Provisions

- **DOH Provider Contract Guidelines for MCOs and IPAs**
  - Contain the mandatory provisions that must be in all provider contracts, the minimum statutory requirements that govern provider and plan contracts, and DOH's oversight over MCO provider contracts
- **DOH Standard Clauses must be attached to and incorporated into all provider contracts**
- **Some Key Provisions covered by the Standard Clauses**
  - No balance billing of consumers
  - Continuity of Care
  - Term and Termination
  - Sharing of enrollee medical records and other personal health information, including HIV, substance abuse, and mental health records
    - Consent obtained on Medicaid enrollment application

Provider Contracts (Cont.) Regulatory Provisions

- **Statutory Provider/Consumer Protections Include:**
  - Provisional credentialing
  - Medical necessity appeals
  - External appeals
  - Limits on prior authorization
    - Understand the distinction between services that must be authorized by the MCO (cost-effective alternative services or "in-lieu of services" and those included in the person-centered service plan by special behavioral health service providers)
  - Prudent layperson
  - Prompt pay – timeframes and interest
  - Overpayments
  - Claim submission timeframes and exceptions

Provider Contracts (Cont.)
Contractual Obligations Imposed on Medicaid MCOs

- **The Medicaid Managed Care Model Contract is the contractual agreement between DOH and each MCO, and contains the requirements imposed on the MCOs and downstream entities**
  - The Model Contract applies to all MCOs without variation
  - Available online - http://www.health.ny.gov/healthcare/managedcare/docs/medicaid_managed_care_fhp_hiv-snp_model_contract.pdf
  - Great resource to understand how providers can partner with MCOs to meet the MCOs' contractual obligations with DOH
    - Some requirements will in turn be imposed by the MCO on the provider
    - Other requirements the MCO could use the provider to help satisfy
- **HARP**
  - RFQ

Provider Contracts (Cont.)

Contractual Obligations Imposed on Medicaid MCOs

- **Network adequacy**
  - MCOs and HARPs must provide a full array of mental health and chemical dependency service providers in sufficient numbers to assure accessibility using individual practitioners and OMH and OASAS providers
    - But no "any willing provider" rule
- **Access requirements (Hours / Time / Distance / Cultural Competency)**
  - Urgent Care Appointments – within 24 hours of request
  - Follow-up (after emergency or inpatient admission) with a mental health or substance abuse provider - within 5 days of request
  - Non-urgent mental health or substance abuse visit – within 2 weeks of request
  - MH/SUD assessment – within 10 days of request
  - MCOs must reimburse certain providers for medical language interpreter services
- **Provider directory**
  - MCOs must make available a list of participating mental health and chemical dependence service providers and specify those that serve children

Provider Contracts (Cont.)
Contractual Obligations Imposed on Medicaid MCOs

- **Encounter Data**
  - MCOs must submit encounter data twice a month or be subject to sanctions ($2,000/day)
  - Provider contracts may impose financial penalties on the provider if the provider fails to submit required encounter data
- **MCOs must operate a quality assurance program and adhere to Quality Assurance Reporting Requirements ("QARR") reports. QARR reports are publically available and it is useful for providers to understand how each MCO performs**
- **New QARR measures specific to MH/SUD to be developed by HARP**
- **Can the provider help the MCO improve its QARR performance?**

Provider Contracts (Cont.)
Contractual Obligations Imposed on Medicaid MCOs

- **Can the Provider collaborate with the MCO on some of the MCO's contractual obligations?**
- **For instance, the Medicaid Model Contract requires that MCOs**
  - Provide health education to enrollees on MH/SUD
  - Case management, including referral to health homes, for enrollees with chronic or ongoing mental health needs
  - Create systems for care coordination between physical health, chemical dependence and mental health providers and social services

Provider Contracts (Cont.) Compensation

- **Non Risk**
  - Fee-for-service
    - Under HARP, MCOs are required to reimburse special behavioral health service providers on a FFS basis based on DOH established payment rates for 2 years
    - MCO Contract states that certain dually licensed freestanding clinics and OMH outpatient clinics must be paid at least an amount equivalent to the APG rate

Provider Contracts (Cont.) Compensation

- **Value-Based Arrangements**
  - DOH's Policy and the Medicaid Model Contract require MCOs to move away from fee-for-service and to align incentives through a payment system based on alternative payment arrangements
  - Align incentives, but providers must be well-suited to perform under this type of arrangement
  - May require provider reserves depending if there is a certain level of risk assumed
  - Can require the provider to be at risk for its own services and also at risk for the services of other providers

Provider Contracts (Cont.) Compensation

- **Type of Risk Sharing Arrangements**
  - Capitation (Regulation 164)
  - Bundled Payment
  - Share savings (bonus) based on a medical budget
  - Share Risk based on a medical budget
  - Payments based on quality outcomes or targets
    - Outcome measures
      - Reducing medically unnecessary services – e.g., inpatient hospitalizations and readmissions
    - Process measures
      - Providing proper follow-up care to a MH/SUD provider after inpatient hospitalization
      - Medication adherence
    - Reporting of data

Provider Contracts (Cont.)
Department of Financial Services (DFS) or Department of Health Review

- **DFS (Regulation 164)**
  - Any pre-paid capitation or percentage of premium
- **DOH**
  - Review of all compensation methods and has financial review criteria for 5 specific risk level categories
- **Depending on the level of risk assumed, determines the level of financial scrutiny and oversight of the provider**
- **DFS or DOH Financial oversight can include:**
  - Financial Security Deposit
  - Security in trust, letter of credit, funds held by MCO, stop loss
  - Out-of-network bank account
  - 12-month financial projections and certified financial statements
  - MCO and the regulatory agency has the right to audit and inspect the provider's books and records

Provider Contracts (Cont.) Payment Issues

- **When to Contemplate a Risk Arrangement:**
  - Understand your data (information technology capabilities)
  - Manage utilization (find ways to save money)
    - Who is performing the assessments, creating the plan of care, managing, coordinating and approving care?
  - Mutuality (risk and reward)
  - Control over the services in which you are assuming risk
  - Risk for own services
  - Risk for services other providers render

Other Things to Know and Consider

- **Business profile of MCO and Provider**
  - How much business can you bring to the table?
  - Can you help MCO meet state requirements – quality measures and goals, network adequacy requirements, etc.?
- **Competitors of MCO and Provider**
  - What distinguishes you from other providers and can you help the MCO distinguish itself from other MCOs?
- **Strengths and opportunities**
  - Quality of services
  - Financial health
  - System capabilities - IT
- **Partnership to foster win / win**

IPA Contracts

- **The contract between the IPA and the IPA Participating Providers ("downstream entities")**
  - Contain similar provisions as a provider agreement
- **The contract between the MCO and IPA**
  - Must always be approved by DOH
  - Key Issues:
    - Governance of the IPA
    - Payment of claims
    - Exclusivity with the MCO and the MCOs ability to exclude certain downstream providers
    - Credentialing
    - Risk sharing

Management Contracts

- **An agreement between an MCO and a MSO that delegates:**
  - the maintenance of books and records
  - disposition of assets and the incurring of liabilities normally associated with the day to day operations of the MCO
  - implementation of policies affecting the delivery of health care services
  - claims payment
  - implementation of MCOs budgets and provision for annual audits;
  - quality assurance and improvement
  - utilization review activity
  - all or part of the functions of the special investigations unit
- **Care Coordination by an MLTC or MAP requires special treatment as a Care Management Administrative Services Agreement**

Management Contracts (Cont.) Key Terms

- **Regulatory Provisions (Management Contract Guidelines and Standard Clauses)**
  - DOH Approval is required prior to implementation (90 days at least)
  - "Sole agreement" clause
  - No more than 5-year term
  - Renewals are subject to DOH approval
  - Any amendments are subject to DOH approval
  - Termination or non-renewal on no less than 90 days' prior written notice to DOH
  - The Management Contract must specify:
    - Reporting and monitoring requirements
    - Performance criteria
    - Staffing and resources allocated to meet the MSO's obligations

Management Contracts (Cont.) Regulatory Review Process

- **DOH Contract Guidelines**
  - http://www.health.ny.gov/healthcare/managedcare/pdf/mgmtcontractguidelines
    - Character and Competency
    - MSO approval to do business in NY
    - MSO's financial stability (audited financials)
    - Evidence of financial feasibility of the contract (projected operating and capitol budgets)
- **Management Contract Statement and Certification form**
  - http://www.health.ny.gov/forms/doh-4255.pdf

QUESTIONS