Managed Care Contracts: The Win-Win Approach

NatCon 17 PreConference Institute
1:00-5:00 pm
Disclaimer: EDUCATIONAL ONLY

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Learning Objectives

• After completing the training, participants will be able to:
  – Describe new payment models they can leverage to reward clinical outcomes and coordinated delivery of services
  – Implement a new managed care marketing strategy that aligns payer and provider incentives
  – Analyze managed care contracting arrangements to negotiate win-win contracts that mitigate legal and financial risk
Go-To-Market Strategy: The Win-Win Approach to Managed Care Contracts

A Go-To-Market Strategy is your plan for taking an idea—tailored to your organization’s strengths—and delivering a service designed to meet or exceed your customer’s needs.
Drucker’s “5 Most Important Questions”

The 5 Most Important Questions You Will Ever Ask About Your Nonprofit Organization*:

• What is our mission?
• Who is our customer?
• What does our customer value?
• What are our results?
• What is our plan?

Drucker, Peter F. 1993.

*These “Five Questions” provide the framework for your GTM Strategy
Developing Your Go-To-Market Strategy

Your GTM Strategy for “Win-Win managed care contracts consists of 6 dynamic phases:
Today’s Agenda

• 1:00-1:30 Internal & External Analysis
• 1:30-2:00 Design
• 2:00-3:45 Contract Evaluation & Negotiation
• 3:45-4:15 Delivery & Growth
• 4:15-4:45 Case Study
• 4:45-5:00 Wrap-Up
GTM PHASE 1: INTERNAL ANALYSIS
GTM Phase 1: Internal Analysis

There are 2 key components to an internal strategic analysis—the starting point of a GTM plan for managed care contracting:

- Organizational Capabilities Review
- Organizational Strategy Review
An internal analysis of strengths asks:

- What do we do really well?
- What are we most known for?
- What can we do that others can’t?
- What can we leverage to do something new?
- How can we deliver exceptional customer experience?
Before seeking managed care contracts, assess your organization’s managed care capabilities in 3 areas:

- Administrative
- Clinical
- Technology
GTM Phase 1A

Managed Care **Administrative** Readiness

- Provider contracting and credentialing processes
- Systems to facilitate preauthorization, clinical criteria, documentation, re-authorizations and case reviews
- Revenue cycle management: end-to-end billing and collections for both payer and consumer
- Encounter data reporting and financial reconciliation
- Managed care-focused performance measurement and reporting
- National Accreditation
GTM Phase 1A
Managed Care **Clinical** Readiness

- Licensed, credentialed clinicians
- Quick, convenient access to care
- Integration with medical, behavioral, and social service partners
- Evidence-based, solution-oriented practices aligned with payer needs
- Standardized service delivery across locations/geography
- Peer and/or family support models
- Demonstrated outcomes
## GTM Phase 1A

### Managed Care **Technology** Readiness

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<thead>
<tr>
<th>Feature</th>
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<tr>
<td>Health Information Exchange</td>
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<tr>
<td>Utilization management tools</td>
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<td>Population health analytics</td>
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<tr>
<td>Risk stratification &amp; predictive analytics</td>
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<tr>
<td>EHR with consumer portal &amp; SIM messaging</td>
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<td>Web-based consumer self-management resources</td>
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GTM Phase 1B
Organizational *Strategy* Review

Early on in developing your GTM Plan, it’s important to revisit your...
- Service line offerings
- Payer mix
- Target populations
- Value proposition

...and make any necessary adjustments for today’s market needs.
A strategic internal analysis explores:

- Where do we play?
- How do we win?
- What’s our potential?
- What are our risks?
- How will we move forward?
GTM Phase 1B
An Organizational *Strategy* Review Helps You Answer 5 Key GTM Questions:

- What are we hoping to achieve?
- How do we leverage our capabilities to deliver services valued by managed care payers?
- What are the gaps between our current competencies and the competencies we need to succeed?
- What services, populations, and customer-types do we need to focus on?
- What is our value proposition?
What is a Value Proposition?

A Value Proposition is a positioning statement that explains what benefit you provide, for who, and how you do it uniquely well.

It describes:

- Your target buyer
- The problem you solve
- Why you’re better than the alternatives
Group Exercise #1: Internal Analysis

• Form small groups and consider the following questions:
  – What are your organization’s key strategic strengths for managed care contracting?
  – What challenges/gaps do you anticipate facing in a managed care GTM strategy?

• Share: Your insights with the group
GTM PHASE 2: MARKET ANALYSIS
GTM Phase 2
Managed Care Market Analysis: 4 Steps

1. National Managed Care Market Analysis
2. Local Managed Care Market Analysis
3. Managed Care Opportunity Analysis
4. Competitor/Collaborator Analysis
GTM Phase 2
Market Analysis: The Purpose

Identify the most attractive targets

Understand their needs

Design a better value proposition than the competition
GTM Phase 2
The Behavioral Health Managed Care Market

A GTM Market Analysis Asks:

• What does the overall BH Managed Care Market look like?
• What does the BH Managed Care Market in your state/region look like?
• Who are your target managed care customers and their key characteristics?
• What are the needs of those managed care targets?
A managed care market analysis helps you do two big things:

- Identify the most attractive target MCOs and their needs
- Design a better value proposition than the competition
## Who Are The Big Multi-Market Players?

<table>
<thead>
<tr>
<th>Parent Firm</th>
<th># States</th>
<th>Medicaid MCO</th>
<th>ACA Exchange</th>
<th>Medicare Advantage</th>
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<td>2</td>
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<td>Kaiser</td>
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<tr>
<td>WellCare</td>
<td>16</td>
<td>9</td>
<td>2</td>
<td>15</td>
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Who Are The New Managed Care Market Disrupters?

• Tech-enabled Care Coordination:
  - Quartet
  - Valera Health

• Tech-enabled Consumer Experience:
  - Oscar
  - Clover
GTM Phase 2A

National Managed Care Market Analysis

Key Trends in Today’s Managed Care Market:

• Growth in Medicaid Managed Care Enrollment
• Expansion of Behavioral Health Benefits in Medicaid
• Focus on Integration
• Focus on High-Utilizers
• New Requirements on MCOs for Value-Based Payments
GTM Phase 2A

Market Trend 1: Growth in Medicaid Managed Care Enrollment

39 states (including DC) had Medicaid contracts with managed care organizations (MCOs) as of September 2016

31 states (+DC) now cover adults up to 138% of the federal poverty level, mostly in managed care

72.4 million Medicaid enrollees as of February 2016— a 15.1 million increase from 2013

Medicaid managed care penetration increased from 62.2% in 2005 to 72.8% in 2014

States are increasingly shifting long-term services and supports from fee-for-service (FFS) programs into managed care
GTM Phase 2A
Market Trend 2: Expansion of BH Benefits

Greater BH benefits are now available to Medicaid and commercial members due to:

- ACA essential health benefit package
- Expansion of MH parity laws
- Greater inclusion of SUD benefits within BH benefit packages
GTM Phase 2A
Market Trend 3: Focus on Integration

- States and Employer purchasers are moving to full “carve-in” models of managed care, with MCOs responsible for integrating medical, MH, SUD, and Rx
- Medicaid BH “carve-outs” are phasing out:

<table>
<thead>
<tr>
<th>Year</th>
<th>States</th>
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<tbody>
<tr>
<td>2014</td>
<td>Florida, New Mexico, Oregon</td>
</tr>
<tr>
<td>2015</td>
<td>Arizona, Louisiana, New York</td>
</tr>
<tr>
<td>2016</td>
<td>Iowa, Texas, Washington</td>
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<tr>
<td>2017 &amp; Beyond</td>
<td>Colorado, Nebraska, North Carolina, Ohio</td>
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**GTM Phase 2A**

**Market Trend 4: Focus on High-Utilizers**

- Individuals with SMI die 25 years earlier than the general population
- Medicaid enrollees with BH diagnosis have high rates of co-occurring chronic medical conditions
- Health care costs for co-occurring MH/physical conditions 60-70% higher than for people with chronic physical conditions alone

MCOs are implementing value-based care models to improve outcomes for high cost members with complex needs:

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CMS has been driving greater use of value-based payment models in Medicare & Medicaid.

MCOs required to facilitate & support the shift to VBP.

**Medicare:**
- 30 percent of Medicare payments through alternative payment models, by the end of 2016, and 50 percent of payments by the end of 2018.

**Medicaid:**
- New DSRIP Waivers promoting VBP in Medicaid managed care:
  - New York: 90% of Medicaid payments by 2019
  - 2016 National Association of Medicaid Directors report: VPB “rapidly becoming the payment paradigm in Medicaid”
Market Trend 5: New MCO Requirements for Value-Based Payments

Common Value-Based Care Models in BH:

- Bundled Payments
- Pay-for-Performance
- Shared Savings/Shared Risk
GTM Phase 2A

Market Trend 5: New MCO VPB Requirements—Arizona Medicaid

- Gradually moving from Pay 4 Volume to Pay 4 Quality
- Increase the overall service dollars spend in VBP contract arrangements:
  - FY16 target was 5%
  - FY17 target is 25%
- Selective provider contracting
- MCO support to providers to achieve results

- Targeted populations and service provider groups:
  - Phase 1:
    - SMI Clinics
    - ACT Teams
    - High Needs Case Management
  - Phase 2:
    - High Cost High Risk Non-SMI population
  - Phase 3:
    - Remaining Non-SMI population
There will likely be more opportunities for Value-Based Payment partnerships with MCOs in markets where the MCOs manage the full benefit: Medical, MH, SUD, Pharmacy
Step 1: Identify your local market

- What is your target market?
- How can the overall market be divided?
  - Geographic
  - Demographic
  - Service Type
  - Payer Type
- How does your local market compare to other/national markets?
GTM Phase 2B

Local Market Analysis

Step 2: Identify the local MCOs and what they are doing in your market

- Market demographics
- Commercial, Medicaid, Medicare, Dual-Eligible Enrollment
- Enrollment by MCO, by membership type
- Major employers in market, and their MCOs
- Behavioral health management model of MCOs
GTM Phase 2B

Local Market Analysis: Behavioral Health Management Models

MCOs use 1 of 3 approaches to managing behavioral health benefits

Strategy 1: Internal BH Strategic Business Unit

Strategy 2: Corporate BH Partner

Strategy 3: External BH Vendor
GTM Phase 2B

Local Market Analysis: Internal BH Management Model

Anthem
BlueCross BlueShield

Cigna

Molina Healthcare

Humana
Behavioral Health

WellCare

aetna
Local Market Analysis: External Vendor BH Management Model
GTM Phase 2B

*Local* Market Analysis: External Vendor BH Management Model

[Logo: beacon health options]

[Logo: Magellan Health Services]

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Local Market Analysis: Understanding Your Potential MCO Partners

• Each of the BH MCOs has a different:
  – Customer segmentation
  – Experience base
  – Corporate culture
  – Size, legacy & complexity factors
  – Geographic footprint
  – Approach to provider contracting/ partnerships
  – Readiness/willingness to engage in value-based contracting models
Managed Care Opportunity Analysis

A national and local managed care market analysis enables you to:

• Understand MCO customer segmentation in your market
• Develop insights into MCO customer needs
• Begin to define your service offering to MCOs via an opportunity analysis
GTM Phase 2C

How to Do A Managed Care Opportunity Analysis

Review MCO market data and prioritize health plans for contracting outreach

- Based on factors such as covered lives, populations served, behavioral health management model

Call/meet with health plans to learn more about their:

- Local market network needs/gaps, and priorities
- Populations and geographies covered
- Plans for network growth to meet new contract needs
- Preferred Provider models and requirements
- Value-Based Purchasing initiatives
- Clinical, administrative & technical resource sharing with network providers
- Interest in, and process for developing new service lines to meet their market needs
Managed Care Opportunity Analysis: Likely Findings

Common MCO network needs include:

- Care Transitions
- Complex Care Management
- Outpatient Medication Assisted Treatment
- Psychiatry/Tele-psychiatry
- Integrated Health Homes
GTM Phase 2D
Competitor/Collaborator Analysis

To Create a Competitor/Collaborator Analysis:

• Create a list of your main competitors in your geographic service area or expansion area
• Create a list of other possible competitors in your state and national competitors entering your market
• Conduct market research regarding their programs and market share
• Analyze your data to gain a knowledge of who are competitors and who may be potential collaborators
GTM Phase 2D

Competitor Profile: Provider X (Example)

Competitor Website:

Primary Organization Function:

Primary Markets:

Annual Revenue: $

Profit/Loss: $

Profit Margin: $

Programs/Services Offered:

- Outpatient behavioral health clinics
- Specialty psychiatric evaluations
- In-home services
- Psychiatric stabilization
- Outpatient MAT
- Care Transition Program
GTM Phase 2D
Competitor/Collaborator Analysis: New Players
Pay attention to potential new market entrants:

• Multi-State “Traditional” BH Provider Organizations:
  Centerstone

• Venture-Funded Start-ups:
  CleanSlate
  mindoula®

• Technology-Enabler:
  lantern
Group Exercise: Market Analysis

- Form small groups and consider the following:
  - What MCOs are in your market?
  - What needs do you suspect that MCOs may have in your market that you can help them meet?
  - What experience have you had in developing solutions to MCO needs?
- Share: Your insights (and success stories) with the group
GTM PHASE 3: DESIGN
GTM Phase 3
Design: The Overall Process

Customer & Market Intelligence  Value Proposition Definition  “Offering”
GTM Phase 3
Go-To-Market Design

GTM Market Analysis enables an organization to:

- Identify attractive target customers
- **Design** value propositions tailored to those target customers & your organization’s strengths
For *(target customers)*...

- Who are dissatisfied with *(the current alternative)*
- Our service is a *(new model)*
- That provides a *(key problem-solving capability)*
- Unlike *(the current alternatives)*.
Designing your MCO “offering:”

- Meet with target MCO(s) to identify their market problems and needs
  - MCO strategic, clinical, & network leadership
- Draft model/concept
  - Design components
  - Organizational capabilities to deliver
- Obtain MCO feedback & revise draft model
- Price your model
  - What are your costs?
  - What pricing strategy can create win/win?
- Proposal to MCO with clear requirements for service offering geared to the target customer(s)
GTM Phase 3
Design: Key Considerations

When designing your MCO offering, ask yourself:

• What’s in it for them (MCO)?
• How does your service offering enhance their business goals?
• Does your model deliver what the MCO wants, and nothing more to distract from the value?
• What is the most advantageous pricing structure/model for them and for you?
• Can you design a better value proposition than your competitors?
GTM PHASE 4: CONTRACT EVALUATION & NEGOTIATION
Evaluating the Contract

Assemble your contract review team

Identify needed areas of expertise
Establish a “point person” and review team lead
Assign team members areas of contract to review based on their expertise
Encourage team members to develop their own checklists to review contracts consistently
Evaluating the Contract

Assemble key documents

Obtain entire proposed contract from MCO, including all referenced and incorporated documents, exhibits, and appendices

Do not assume MCO knows your scope of services!

Obtain other documents necessary to understand MCO’s legal obligations (for example, in Medicaid managed care, the MCO’s contract with the State)

For “innovative” service offerings, draft key business terms reflecting the unit of service, unit of payment, payment procedures, etc.
Evaluating the Contract

Assess the MCO’s Operational Performance

Considering past performance of the MCO is crucial.

• Did the MCO meet its payment obligations on time?
• Did the MCO timely credential practitioners?
• Did the MCO timely provide prior authorization?
• Were the basis for denied claims clean and reasonable?
• 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?
Evaluating the Contract

Review Contract Terms

Do you understand what all provisions mean?
What provisions disadvantage your organization from a financial, clinical, operational, or legal perspective?
Are responsibilities for each party clearly stated and all terms defined?
Does the contract include all of the relevant appendices and exhibits?
Have you reviewed any policies, procedures and documents referenced in the contract?
Have you reviewed any references to statutes, codes, regulations to know what they say?
Is the contract consistent with all other applicable Federal and State legal requirements?
Does the contract reflects sound business judgment?
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 payer.

- The scope of services section of the contract specifies which covered plan services the provider is responsible for providing.
- **Test for under-inclusiveness:** Does the scope of services describe all of the services you furnish?
- **Test for over-inclusiveness:** Does the scope of services describe any services you do not furnish?
Covered Services

Distinguish your **scope of services** from the enrollee’s **covered services** (i.e., the services available under the enrollee’s benefit plan).

Services must fall within both Covered Services and Scope of Services in order to receive payment from an MCO.

Often 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.

Determine whether there are any significant coverage limitations that apply to services you provide

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

Review the documentation requirements to bill a patient for 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
“All Products” Clauses

MCOs frequently pay providers at different rates for various lines of business (private commercial insurers, Medicare Advantage, Medicaid.)

An “all-products” clause requires the provider to participate in all products (and rates) offered by the MCO (both currently and prospectively)

Providers should have the ability to opt-out of any new products offered by the MCO.
### NYS RFQ FOR BEHAVIORAL HEALTH

#### Payment/Scope Protections

<table>
<thead>
<tr>
<th>Provider/Service Type</th>
<th>Payment Requirement</th>
<th>Reference</th>
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</thead>
<tbody>
<tr>
<td>OMH or OASAS licensed or certified providers</td>
<td>Must pay no less than Medicaid FFS rates for period of 24 months</td>
<td>§ 3.7.B.iii.a.</td>
</tr>
<tr>
<td>OASAS residential programs</td>
<td>Must pay allied clinical service providers on a single case or contracted basis</td>
<td>§3.6.D.</td>
</tr>
<tr>
<td>Clinics holding a state integrated license</td>
<td>Must contract for full range of services available under license</td>
<td>§ 3.6.G.</td>
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Timely Claiming Rules

MCOs typically require the submission of claims no more than 90 days after the date of service.

- Determine whether state law or other obligations on the MCO dictate a longer claims filing period.

Review the proposed contract for provisions concerning the consequences of late claim submission.

- Negotiate for a provision that makes MCO denial of late claims discretionary rather than mandatory.
A.2.12.9.28
Timely Claiming Rules

- Provide for prompt submission of information needed to make payment. Specify that a provider shall have one hundred twenty (120) calendar days from the date of rendering a covered service to file a claim with the CONTRACTOR except in situations regarding coordination of benefits or subrogation in which case the provider is pursuing payment from a third party or if an enrollee is enrolled in the MCO with a retroactive eligibility date. In situations of third party benefits, the maximum time frames for filing a claim shall begin on the date that the third party documented resolution of the claim.

- In situations of enrollment in the CONTRACTOR’s MCO with a retroactive eligibility date, the time frames for filing a claim shall begin on the date that the CONTRACTOR receives notification from TENNCARE of the enrollee’s eligibility/enrollment;
Prompt Payment Rules

Just as the MCO has an interest in timely claims submission, a provider has an interest in timely payment.

- A “clean claim” is a claim, received by a MCO for adjudication, that requires no further information, adjustment, or alteration by the provider of the services, or by a third party, in order to be processed and paid by the MCO. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

- Providers should seek to have prompt pay rules, including any automatic interest provisions, written into the provider agreement.

- Providers should have right to receive a written explanation for all denied claims and the information that is needed by the MCO to process the claim for payment.
## TENNESSEE MODEL CONTRACT

### Prompt Payment / Denied Claims Protections

<table>
<thead>
<tr>
<th><strong>A.2.12.9.29 (Prompt Payment)</strong></th>
<th><strong>A.2.22.4.7 (Denied Claims)</strong></th>
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<tbody>
<tr>
<td>Provide for payment to the provider upon receipt of a clean claim properly submitted by the provider within the required time frames as specified in TCA 56-32-126 and Section A.2.22.4 of this Contract;</td>
<td>• If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice or other appropriate written or electronic notice shall specifically identify all such information and documentation.</td>
</tr>
<tr>
<td><strong>A.2.22.4.2</strong></td>
<td>• Resubmission of a claim with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.</td>
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<tr>
<td>• The CONTRACTOR shall ensure that ninety percent (90%) of clean claims for payment for services delivered to a TennCare enrollee are paid within thirty (30) calendar days of the receipt of such claims.</td>
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<tr>
<td>• The CONTRACTOR shall process, and if appropriate pay, within sixty (60) calendar days ninety-nine point five percent (99.5%) of all claims for covered services delivered to a TennCare enrollee.</td>
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# NEBRASKA MEDICAID RFP

## Prompt Payment / Denied Claims Protections

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<tr>
<th>Prompt Payment</th>
<th>Denied Claims</th>
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<tbody>
<tr>
<td>• The RFP requires MCOs to pay or deny <em>ninety percent (90%) of all clean claims within fifteen (15) calendar days of receipt, ninety-nine percent (99%) of all clean claims within sixty (60) calendar days of receipt, and one hundred percent (100%) of all claims within six (6) months of receipt.</em></td>
<td>• The related remittance advice must <strong>be sent with the payment</strong>, unless the payment is made by EFT. Any remittance advice related to an EFT must be sent to the provider no later than the date of the EFT.</td>
</tr>
<tr>
<td>• A “clean claim” is a claim, received by a MCO for adjudication, that requires <strong>no further information</strong>, adjustment, or alteration by the provider of the services, or by a third party, in order to be processed and paid by the MCO. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.</td>
<td>• If a claim is partially or totally denied because the provider did not submit required information or documentation with the claim, then the remittance advice must <strong>specifically identify all the required information and documentation not submitted</strong>. Resubmission of a claim with the necessary information/documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.</td>
</tr>
<tr>
<td>• The MCO must pay providers interest <strong>at an annualized rate of 12%</strong>, calculated daily for the full period in which a payable clean claim remains unpaid beyond the <strong>60-day claims processing deadline</strong>.</td>
<td>RFP, § IV.S.6, p. 167.</td>
</tr>
<tr>
<td>• Interest owed to the provider must be <strong>paid the same day that the claim is adjudicated</strong>, and reported on the encounter submission to MLTC or its designee.</td>
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RFP, § IV.S.3,5, p. 163,166 and Glossary
Correction of Overpayments & 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.

- Determine whether there are any limits on the MCO’s timeframe for recouping overpayments from a provider.

- Determine whether the contract requires the MCO to provide notice of the alleged overpayment (and afforded the provider an opportunity to appeal the determination) prior to offset.

- Determine whether the contract permits the provider to dispute underpayments within a time frame that is equal to the time frame that a MCO may recoup overpayments.
### Recoupment of Overpayments Protections

<table>
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<tr>
<th>Notice Period</th>
<th>Explanation</th>
<th>Time Period</th>
</tr>
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</table>
| Except duplicate payments, requires 30 days' notice prior to recovery of overpayment (e.g., by offset) | • Patient name
• Service date
• Payment amount
• Proposed adjustment
• Reasonably specific explanation of proposed adjustment | Recovery may not occur after 24 months of original payment, except for (1) recoveries based on fraud, intentional misconduct or abusive billing and (2) Medicaid enrollees |
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.

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

- Informal negotiation
- Mediation
- Arbitration (binding) or judicial remedies

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Collecting Patient Cost-Sharing

As in traditional Medicare and Medicaid, the provider is responsible for collecting cost-sharing (copayments, coinsurance, and deductibles) required under the terms of the enrollee’s plan.

Under MCO contracts, providers are at financial risk for the collection of any cost-sharing amounts.

Practice Pointer: Determine applicable cost-sharing amounts, particularly deductibles, applicable to MCO product lines.

Practice Pointer: Cost-sharing should be collected at the time of the visit, either before or after services are rendered.
Waiver or Reduction of Cost-Sharing

In many cases, the MCO does not permit a provider to reduce or waive the amount of cost-sharing owed by a patient.

- Providers should seek a modification that allows it to waive or reduce cost-sharing amounts for individuals who qualify under the provider’s charity care policy, if any.
- 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.
Access Standards

Access standards define the required level and availability of care from a patient-centered perspective, including:

- **required hours and days of operation** (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**
- **maximum waiting-room times**
### Access Standards

<table>
<thead>
<tr>
<th>Appointment Availability Access Standards</th>
<th>Scheduled Appointments</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Emergency services must be available <em>immediately upon presentation</em> at the service delivery site, 24 hours a day, seven days a week.</td>
<td>Wait times should not routinely exceed <strong>45 minutes</strong>, including time spent in the waiting room and the examining room, unless the provider is unavailable or delayed because of an emergency.</td>
</tr>
<tr>
<td>- Members with emergent behavioral health needs must be referred to services <em>within one hour generally and within two hours in designated rural areas</em>.</td>
<td>If the provider is delayed, the member should be notified immediately.</td>
</tr>
</tbody>
</table>


If a wait of more than 90 minutes is anticipated, the member should be offered a new appointment.
Regulatory Penalty Provisions

Some contracts hold a provider liable for any fines or penalties assessed against the MCO by a state or federal regulatory agency that result from a provider’s non-compliance with a requirement under the contract or provider manual.

- Under these provisions, providers will be liable even if:
  - MCO was unaware of the non-compliance, took no steps to monitor the provider, or correct the provider’s non-compliance.
  - Provider did not act negligently but made good faith efforts to comply.
  - Providers do not have authority to appeal or dispute the regulatory agency’s fines or penalties against the MCO.
  - Providers should avoid incurring liability for fines or penalties assessed against MCO.
## Licensure – Contract Provisions

<table>
<thead>
<tr>
<th>Notice</th>
<th>Consequence</th>
</tr>
</thead>
</table>
| • MCO contracts typically require that provider report any loss of licensure immediately to MCO  
• Providers should seek to avoid contract provisions that require that the provider report to the MCO whenever a clinician is in danger of losing license (e.g., under investigation), as divulging information at that stage could be a liability risk | • Failure to maintain licensure is in some contracts grounds for immediate termination  
• Loss of licensure by one clinician should not trigger immediate termination, so long as provider has continuing capacity to perform |
Credentialing – Timing

Most MCO contracts provide for credentialing at the outset of the contract and at regular intervals (e.g., every three years)

- MCO credentialing of a practitioner must be effective on the date of service in order for the provider to receive payment for services to an MCO enrollee
- MCOs may provide a maximum timeframe for completion of credentialing (usually around 30 days), but only upon the MCO’s receipt of a “complete application”
- **Practice Pointer:** Delay new practitioner’s start date until credentialed by at least one MCO
Provider Credentialing

Required Timeframes

- The MCO must completely process credentialing applications from all provider types within 30 calendar days of receipt of a completed credentialing application. A completed application includes all necessary documentation and attachments. "Completely process" means that the MCO must:
  - Review, approve, and load approved providers to its provider files in its system and submit the information in the weekly electronic provider file to MLTC or MLTC’s designee, or
  - Deny the application and ensure that the provider is not used by the MCO. A provider whose credentialing/re-credentialing application is denied must receive written notification of the decision, with a description of his/her/its appeal rights.
- The MCO must accept provider credentialing information submitted via the Council for Affordable Quality Healthcare (CAQH) system.
- The MCO must also accept any standardized form and/or process for applicable providers within 60 calendar days of its development and/or approval by the administrative simplification committee and MLTC.

RFP § IV.I.14., p. 100-01.
## Facility-Based Credentialing Protections

<table>
<thead>
<tr>
<th>Topic</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Credentialing of OMH and OASAS licensed or certified programs</td>
<td>License or certification must suffice for the Plan’s credentialing process.</td>
</tr>
<tr>
<td></td>
<td>Plans are prohibited from separately credentialing individual staff members in their capacity as employees of these programs.</td>
</tr>
<tr>
<td></td>
<td>Plans must contract for the full range of services offered under the programs’ license or certification.</td>
</tr>
</tbody>
</table>
Delegated Credentialing

Some providers have succeeded in negotiating a “delegated credentialing” relationship (i.e., the provider performs credentialing on behalf of the MCO, under MCO’s oversight)

MCO saves costs; provider gains control over timing

Delegated credentialing typically requires provider to use national standards (e.g., National Committee for Quality Assurance)
Delegated Credentialing Protections

A. 2.11.9.1.3 Provider Credentialing

To the extent the CONTRACTOR has delegated credentialing agreements in place with any approved delegated credentialing agency, the CONTRACTOR shall ensure all providers submitted to the CONTRACTOR from the delegated credentialing agent is loaded to its provider files and into its claims processing system within thirty (30) calendar days of receipt.
Utilization Management

UM programs are relevant to behavioral health providers because:

• MCOs often impose prior authorization or visit limits for behavioral health services
• MCOs often require authorization before ordering certain drug screening tests
• MCOs increasingly require prior authorization before a provider may refer patients for rehabilitative services
Utilization Management – “Medical Necessity”

The core function of the UM program is to ensure that the MCO pays for only those services that are “medically necessary”

Involves a determination of whether the service is necessary and appropriate for the patient’s symptoms, diagnosis, and treatment

The definition of “medically necessary” in the MCO contract is of critical importance to the provider and the enrollee

Many MCO contract definitions of “medically necessary” state that services may not be provided primarily for the convenience of the patient or the provider

The contract should specify all services that will be subject to UM
### A. 2.14.4.4

**Behavioral Health Services**

- The CONTRACTOR shall **not** require a PCP referral for members to access a behavioral health provider.
## Behavioral Health Parity

- Must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA). This includes:
  - Making the criteria for medical-necessity determinations for mental health or substance abuse disorder benefits *available to any current or potential member, or contracted provider, on request.*
  - *Providing the reason* for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members.

RFP § IV.E.3., p. 53.

## Medically Necessary Services

- MCO must specify what constitutes “medically necessary services” *in a manner that is no more restrictive than the State Medicaid program* and addresses the extent to which the MCO is responsible for covering services related to the following:
  1. The prevention, diagnosis, and treatment of health impairments.
  2. The ability to achieve age-appropriate growth and development.
  3. The ability to attain, maintain, or regain functional capacity.
- The MCO *may not limit services* beyond the limitations in the State’s Medicaid program.

RFP § IV.E.4., p. 53.
<table>
<thead>
<tr>
<th>MCO contract provisions or manual should specify:</th>
<th>Documents that the provider must submit to the MCO for the review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Special procedures for obtaining emergency authorization for services</td>
</tr>
<tr>
<td></td>
<td>The grievance / appeal procedure available to contest the denial of prior authorization (by either the enrollee or the provider on the enrollee’s behalf)</td>
</tr>
<tr>
<td></td>
<td>Whether under any circumstances the provider may obtain payment when the criteria for prior authorization were met, but the provider failed to timely request prior authorization.</td>
</tr>
</tbody>
</table>
# Parties to the Contract

Your contract with the MCO should:

<table>
<thead>
<tr>
<th>Specify the parties to the agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affirm that the provider and MCO are independent contractors</td>
</tr>
<tr>
<td>Include a provision stating that the contract is not enforceable by third party beneficiaries</td>
</tr>
</tbody>
</table>
Breach and Cure

Breaches (violating 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
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.

Recognize that when contracts may be terminated without cause, the notice period becomes the effective term of the contract.
Renewal

Renewal of the agreement usually means renewal of the payment terms for the subsequent term.

- The contract should specify if renegotiation of payment terms must occur after one party notifies the other party of its desire to renew.
Amendments

Scope

• 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.
• Determine whether the amendments clause applies solely to the contract itself or also includes documents incorporated by reference, such as “program attachments”, “payment exhibits”, and the MCO’s policies and procedures.

Provider Rights

• Immediate amendment: Notice (only for regulatory or statutory changes)
• Auto-amendment: Notice and right to opt-out (non-regulatory amendments)
• Written amendment: Notice and Consent (signed by both parties)

Initiator

• Providers should also have right to propose contract amendments.
Indemnification

Indemnification provisions state which party to a contract bears the risk (and liability) for certain events or acts of third parties.

- A party is “indemnified” if, by virtue of a contract provision, it avoids assuming responsibility for another party’s acts or omissions arising out of performance of the contract.
- Indemnification clauses should apply to both parties.

The contract should allocate responsibility:

- to the MCO for coverage decisions, selection of providers, utilization management activities, compliance with state and federal insurance laws, and other acts within its control.
- to the provider for professional medical judgment (including malpractice claims), medical record documentation requirements, accurate claims submission, and other acts within the provider’s control.
Evaluating the Contract

Identify and *Prioritize* Issues

Categorize each issue as follows:

**Red**: Critical issues that without addressing you cannot afford to proceed because the risks (not just financial) are unacceptable for the organization.

**Yellow**: Significant issues that should be addressed before proceeding because they create undesirable risks for the organization.

**Green**: Issues that ideally would be addressed prior to proceeding to reduce potential risks.
Negotiate

Your idea of negotiation?
Negotiate

Negotiation is discussion aimed at reaching an agreement.
Negotiating Logistics

Preliminary questions

• Who will be negotiating?
  • A team?
  • An individual?
• How will issues be negotiated?
  • In writing?
  • By phone?
  • In person?
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.

occurs when parties take extreme positions in the expectation that they will have room to bargain down.
Negotiating the Contract

- Look for zones of agreement and areas of overlap
- Develop options for mutual gain and generate a variety of possibilities
- Focus on underlying interests
- Respond with questions, rather than statements
- Respond specifically to the MCO’s concerns
Negotiating Tips

**Educate:** Do not assume that the MCO’s representative understands your concerns.

**Learn:** Respond with questions, rather than statements, and respond specifically to the MCO’s concerns.

**Voice** options for mutual gain and generate a variety of possibilities before deciding what to do.

**Insist** that resulting provisions be based on some objective standard.

**State** the importance of maintaining an ongoing relationship.
Negotiating the Contract

If you did not resolve all of the **critical issues** to your satisfaction, consider:

- whether this one MCO contract is essential to your operations
- whether the risks of contracting outweigh the risks of not contracting with the MCO
- whether you can terminate the contract early in the event that the financial or legal harm becomes too great to bear
- whether you have any other options for achieving a better outcome, i.e., using an agent for negotiations
GTM PHASE 5: DELIVERY
GTM Phase 5

Delivery: Fulfilling Expectations

Ensure the successful delivery of your model through:

• Seamless coordination between design and delivery functions/teams
• Training your “front-line” staff to understand the client’s expectations and execute flawlessly
• Following through on contractual and clinical requirements
• Demonstrating outcomes
GTM Phase 5
Delivery: Demonstrate Outcomes

Typical MCO outcome expectations include:

• Clinical effectiveness
• Client access
• Process efficiency (e.g. electronic claims)
• Reduced inpatient utilization
• HEDIS and other national measures
GTM PHASE 6: GROWTH
GTM Phase 6
Growth: Partnering with the MCO

The keys to growing your MCO business are:

• Exceed expectations in performance
• Create MCO advocates who...
  10 Facilitate the relationship internally
  10 Increase referrals to your services
  10 Provide customer feedback for rapid service improvement
  10 Seek opportunities to expand the relationship
GTM Phase 6
Growth: MCO Relationship Management

Cultivate the MCO relationship through formal account management processes

- Maintain regular communication
- Develop relationships with clinical and network staff
- Participate in periodic meetings with MCO clinical staff
- Continually learn about their needs and plans, and how you can help them
- Keep them informed about you
- Track your outcomes, share your data, talk about your accomplishments
GTM Phase 6
Growth: Developing Win/Win Partnerships to Advance Value-Based Care

MCOs are seeking high-value providers with which they can develop preferred relationships that advance value-based care delivery models

Providers are seeking preferred relationships with MCOs to sustain growth and improve service delivery through value-based care
CASE STUDY
Managed Care Contracts: The Win-Win Approach

Debbie Cagle
Chief Marketing Officer
Centerstone at a Glance

- National, private, not-for-profit 501(c)(3) healthcare organization
- 60+ years in operation
- Specializing in the treatment and rehabilitation of individuals with mental illness, addictions, traumas, and intellectual/developmental disabilities
- Five state primary footprint; specialized services spanning all 50 states
- CARF and Joint Commission Accredited
  - Including specialized CARF Accreditation – Adult and Children & Youth Health Home

In FY2016

- People Served
  - 172,000+
  - 49%-Male | 51%-Female
  - All ages served
- Services Provided
  - 2,781,000+
- Staff
  - 5,000+ clinical and administrative staff and a national network of over 700 contract therapists

Signature Service Lines

- Health Homes
- Integrated Primary Care
- MAT/Addiction Services
- Hospital and Crisis Services
- Active Military and Veterans
- Intellectual and Developmental Disabilities
Centerstone Reach

Centerstone’s reach is spread across the United States with concentration in five states: FL, IL, IN, KY and TN.

Centerstone’s psychiatric inpatient unit in Florida and addiction centers in Florida and Kentucky draw patients from across the nation.
Centerstone Contracting

Five state footprint with hundreds of managed care contracts; over 50 active payer discussions at present.

Small, but Experienced Team – 2 1/4 FTE’s supporting five states.

Over 75 years of combined managed care experience.

Team is committed to increasing revenue and developing long-term sustainable contracts.

Dependent on information and state business unit resources to be successful.
Current Fiscal State

**Medical Loss**
- ↑ 105%
- ↑ Utilization (ED + Hospital) MLR
- Need for Value Based Care
- ↓ Paid Claims (MLR + Interest)
- ↓ No Incentive Payment

**Revenue**
- ↓ Paid Claims
- ↑ 105%
- ↓ Incentive
- ↓ ($1M)

Partnership Relationship
Proposed by Health Plan

Medical Loss
- 100% Rates (+5%)
- MLR Utilization (90% of Savings Pool)
  Paid Claims Promise
  Credentialing Promise
- Value Based Care

Revenue
- Infrastructure Cost
- 100% Rates (-5%)
- Incentive (10% of Savings Pool)
  Paid Claims Promise
  Credentialing Promise
- Value Based Care (Fiscal Risk)

Partnership Relationship
Proposed by Centerstone

**Medical Loss**
- ↓ 100% Rates (+5%)
- ↑ 105% Rates (for Limited Select Services)
- ↑ MLR Utilization (60% of Savings Pool)
  - Paid Claims Promise
  - Credentialing Promise
- ↑ Value Based Care

**Revenue**
- ↑ Infrastructure Cost
- ↓ 100% Rates (-5%)
- ↑ 105% Rates (for Limited Select Services)
- ↑ Incentive (40% of Savings Pool)
- ↑ Paid Claims Promise
- ↑ Credentialing Promise
- ↑ Value Based Care (Fiscal Risk)

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#BH365
Final Proposal

Medical Loss

- 100% Rates (+5%)
- MLR Utilization (Tiered Savings Band)
- High Utilizer Pilot with additional new members (new revenue & larger shared savings pool)
- Paid Claims Promise
- Credentialing Promise
- Value Based Care

Revenue

- Infrastructure Cost
- 100% Rates (-5%)
- Incentive (Tiered % of Shared Savings Pool)
- High Utilizer Pilot – addtl. new members (new revenue & larger shared savings pool)
- Paid Claims Promise
- Credentialing Promise
- Value Based Care (Fiscal Risk)

Partnership Relationship
How We Get There

- The Good | The Bad | The Ugly
- Training & Coaching in Change | The New Clinical Norm
- Marketing to MCOs

Managed Care Contracts
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Group Exercise: Putting It All Together

• **Form small groups and:**
• Design a Care Transitions Program for an MCO’s commercial membership.
  – Include the following components:
    • Program Description
    • Core Services Delivered
    • Staffing
    • Outcome Measures
    • Contract Reimbursement Model
• **Share:** Present your Care Transitions Program to the group
Questions & Discussion
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