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Webinars for Wise Nonprofits:
Breaking Down Managed Care
Contracts

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Agenda

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- Introduction to Managed Care Contracting
- Key Considerations for Contracting with Managed Care Plans
- Overview of IPAs
- Understanding HIPAA

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Introduction to Managed Care Contracting

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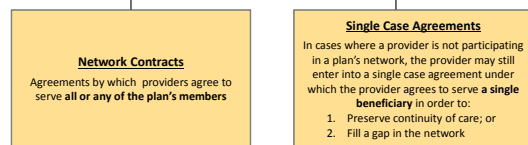
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Managed Care Contracting 101

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Managed care plans must build a network of providers that is sufficient to serve their members and that complies with network adequacy standards that are set by the State.

Providers can enter into two types of contracts with managed care plans



Today's focus

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Common Components of Health Plan Contracts

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Define Responsibilities of Each Party

- **Provider responsibilities** (e.g., services, requirements applicable to those services)
- **Plan responsibilities** (e.g., payment to providers)

Describe Standards and Requirements

- Provider credentialing
- Utilization management
- Provider compensation
- Claims submission and billing
- Indemnification and insurance
- Audit and oversight
- Assignment and amendments

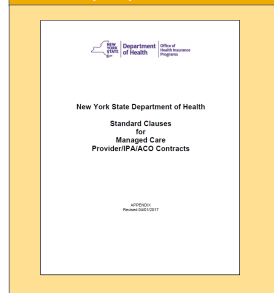
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Required Components of Health Plan Contracts

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New York State Department of Health (DOH) Standard Clauses



Other relevant documents

- Managed care model contracts
- [Medicaid Managed Care Organization Children's System Transformation Requirements and Standards](#)
- [Request for Qualifications for MCOs and HARPs](#)

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Key Considerations for Contracting with Managed Care Plans

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Provider Credentialing

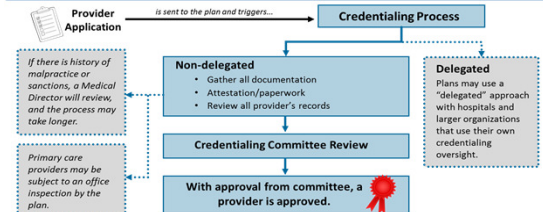
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Managed care plans are required to credential all participating providers.

At the time of contracting and again at least once every three years, the plan must:

- Validate all credentialing requirements
- Search for medical sanctions by DOH and/or Medicaid
- Search the National Practitioners Data Bank

How It Works



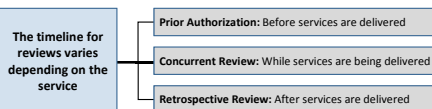
Plans cannot credential certain providers, including those licensed or certified by the Office of Mental Health (OMH) and the Office for Alcohol and Addiction Services (OASAS), and are required accept the agency license or certification for credentialing purposes. Plans are not be allowed to separately credential individual staff in their capacity as employees of the program.

Utilization Management (UM)

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Managed care plans evaluate the appropriateness of new and ongoing services based on medical necessity criteria.

- While UM criteria generally vary by plan, DOH, OMH and OASAS do set some UM criteria.
- Utilization reviews are typically completed by nurses and overseen by the health plan medical director.
- If a service is denied, providers and members may appeal the decision. Health plans must share a written description of the plan's utilization review policies and procedures as well as guidance for appealing an adverse determination.



- ★ For individuals enrolled in health homes, the care plan developed by the health home is key for receiving authorization for the services from the plan.
- ★ Most interventions provided by community based organizations (CBOs) will be subject to prior approval.

Provider Compensation

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Managed care plan contracts must specify the payment rates for services.

Prompt pay laws require that claims be paid within 30 days of receipt of electronic claims and within 45 days of receipt of paper claims.

The State has set benchmark rates for a variety of services, including behavioral health services and nursing home services.

Plan contracts will require providers to confirm a member's enrollment at the time the service is delivered.

- To protect providers in the event of eligibility systems errors, plans should include a provision that ensures the provider will be paid as long as the provider confirmed eligibility with the plan at the time of service.
- Providers typically do this through ePACES, but this can be very problematic for community-based organizations (CBOs) that are not enrolled in Medicaid and do not have access to ePACES. CBOs should attempt to negotiate changes to these provisions.

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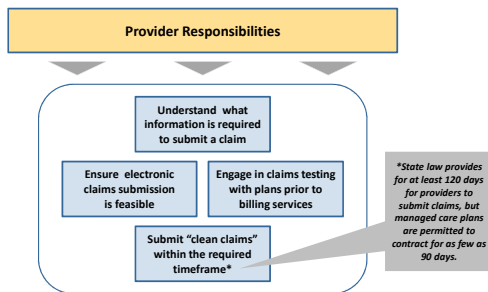
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Claims Submission and Billing

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Managed care plan contracts describe how providers will bill for services.

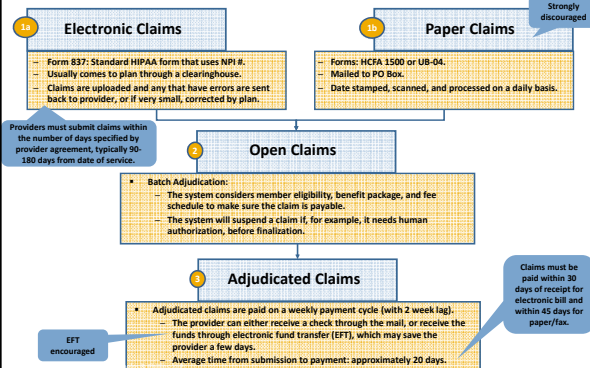


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Overview of Medicaid Managed Care Claims Process

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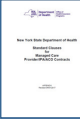


Audit and Oversight

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Health plans and government agencies may perform audits of providers to ensure quality care.



The Standard Clauses require that documents be maintained for six years, but the State is moving toward a 10-year retention period.

- Providers may wish to negotiate limitations on a health plan's audit rights to ensure that audits do not impede business operations (e.g., requiring a specific number of days' prior notice, limiting audits to once per year). The State's audit rights cannot be limited.

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Indemnification and Insurance

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Managed care plan contracts will require providers to have insurance and are likely to specify the minimum amount.

- Indemnification:** In the event one entity is sued as a result of negligence on the part of another entity, the entity responsible must provide compensation.
 - In other words, if an employee or agent of your organization does something negligent and the plan is sued, the plan can seek compensation from your organization.
 - Contracts will require that the provider indemnify the plan and the plan indemnify the provider.
- Insurance:** Contracts will likely require that providers carry general insurance and malpractice insurance policies in the amount of \$1 million/\$3 million.



Providers and CBOs should not agree to carry insurance not applicable to their services.

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Assignment and Amendments

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Managed care plan contracts will include specifications for amendments.

- The contract should require amendments to be in writing and be signed by both parties.
 - This will ensure that the plan does not attempt to unilaterally amend the contract.
- The contract should allow the provider to assign the contract in the event that the provider chooses to sell or merge.

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Overview of IPAs

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Understanding IPAs

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The purpose of an Independent Practice Association (also referred to as an IPA) is to:

- Assemble a network of separate providers who are independent of each other
- Act as a group, enter into a master contract with a health plan on behalf of the entire group
- Collectively negotiate with the health plan regarding key terms and aspects of ongoing operations to serve the health plan's covered members

IPAs are entities which are sometimes utilized in value-based payment contracts.

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Understanding IPAs

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IPAs are entirely optional.

- Providers do not have to create an IPA in order to contract with a health plan.
- Health plans do not have to contract with IPAs.

IPAs are extensively regulated.

- DOH regulations prescribe the role and formation process for IPAs.
- IPAs must carefully navigate antitrust rules.

IPAs can *only* assemble and contract with the network of providers, provide care coordination and assistance to the health plan on other issues (i.e. utilization and quality improvement).

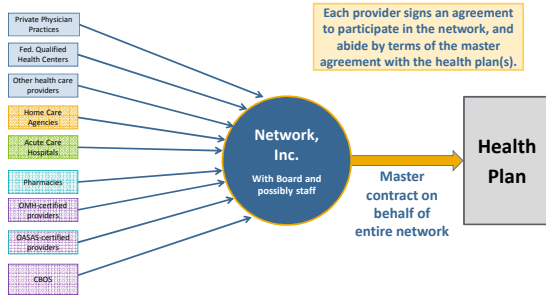
Traditionally, DOH has restricted IPAs from performing management services (i.e. claims payment, quality assurance and improvement, credentialing, fraud detection) and required that the plan contract with a management service company to provide these services.

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Intermediary Contracting Entity

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Understanding Value Based Payment (VBP)

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The State has entered into an agreement with the federal government that requires 80-90% of payments made by managed care plans to providers by 2020.

Value-Based Payment Levels

Level 0	FFS with bonus and/or withhold based on quality scores	Level 2 and 3 contracts must include a tier 1 CBO and a social determinant of health intervention.
Level 1	FFS with upside only shared savings when quality scores are sufficient	
Level 2	FFS with risk sharing (upside available when outcome scores are sufficient; downside is reduced or eliminated when quality scores are high)	
Level 3	Global capitation (with quality-based component)	

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HIPAA and Part 2 Considerations

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HIPAA Privacy Rule Generally

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- In general, the HIPAA Privacy Rule protects patient protected health information (“PHI”) from unauthorized use, access and disclosure.
- PHI is any information relating to an individual’s health status, treatment or payment for health services that is created or received by Client and that may identify the individual.
- Includes oral, written and electronic records and communications.
- The same privacy protections apply to deceased individuals.

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Treatment

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Treatment includes the provision, coordination and/or management of healthcare and related services, including consultations and referrals.

Examples:

- If a patient receives care from a provider, the provider may send the patient’s information to the referring physician
- A nurse may consult with a physical therapist concerning the best approach to the care of a patient they are both treating
- A provider can share information with practices and physicians who are also treating the patient



Health plans do not provide treatment.

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Payment

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Payment includes the activities undertaken by a provider or a payer to obtain payment for its services

Examples:

- A provider or plan is permitted to contact Medicaid or an insurance company to determine if a patient is eligible
- A provider or plan is permitted to release PHI for its own collections purpose
- Provider may share PHI with an MCO to obtain a payment



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Healthcare Operations

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Healthcare operations include routine activities such as quality assurance, case management, credentialing, accreditation, education of staff, business planning and customer service.

- A provider may use PHI to perform quality improvement projects
- Plan may use PHI to evaluate the services of its providers
- Provider may use PHI to conduct training programs for medical students, nursing students and other medical trainees
- Plans and providers can share for joint quality improvement activities if they share a patient/member



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Minimum Necessary Rule

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Staff must **limit the patient information which they use or disclose** to the minimum necessary to accomplish their job responsibilities

Minimum necessary rule applies to disclosures for **payment** and **health care operations**.

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Who Is a “Business Associate” Under the Privacy Regulations?

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- Any person or entity that creates, receives, maintains or transmits PHI **on behalf of a covered entity**, including claims processing or administration, data analysis, utilization review, quality assurance, patient safety activities and billing; or
- Any person or entity who provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or for a covered entity involving the disclosure of PHI.



Covered entities must have a written Business Associate Agreement (BAA) with each of its Business Associates. HIPAA has specific requirements for the content of BAAs.

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Examples of Business Associates

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- ✓ Software vendors, if they need or obtain access to PHI
- ✓ Medical equipment vendors, if they receive or create PHI
- ✓ Administrative service providers, etc.
- ✓ QA consultants
- ✓ Photocopy companies
- ✓ Healthcare providers who perform services other than treatment (e.g., a nurse who provides administrative services)



Health plans are generally not business associates of providers.
Providers are generally not business associates of plans.

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Data Sharing:

Relevant Regulations & Legal Considerations

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There are limits what data can be shared and how data can be shared between plans and payers under HIPAA and Part 2

In general, **HIPAA prohibits the sharing of protected health information between a provider and a plan**, except for **payment and health care operations**



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Part 2

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Some types of data related to substance use disorder ("SUD") services are subject to 42 C.F.R. Part 2

Part 2 Programs include any organization that "**holds itself out**" as providing, and provides, **SUD diagnosis, treatment or referral for treatment and receives federal assistance**

Part 2 is known as a strict privacy regulation because a patient's written consent generally is required prior to disclosing Part 2 data.

In contrast to HIPAA, there is **no exception to Part 2 that allows disclosures without consent for purposes of treatment or care coordination**, nor is there a consent exception that allows a provider to disclose Part 2 data to a health plan in order to **obtain payment**.

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Part 2

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A provider may receive Part 2 data from a health plan

Health plans may hold data that is subject to 42 C.F.R. Part 2.

Health plan discloses the data to provider and tells the provider its Part 2 data

Provider **must** protect the data as Part 2 data

Prohibited from re-disclosing that patient data unless consent is obtained

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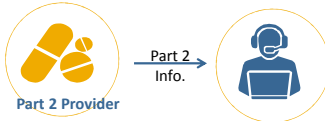
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Part 2 and Qualified Service Organizations

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A Qualified Service Organization (QSO) is a contractor to a Part 2 program that provides services on behalf of that program.

- Similar to a business associate
- But a QSO must directly contract with a Part 2 provider
- If you are a QSO then patient consent is not required to disclose the Part 2 information to the QSO



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Questions

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