North Carolina Community Health Care Association

Understanding the Ins and Outs of Insurance/ Managed Care Contracting

September 10, 2019

Curt Degenfelder
curt@degenfelderhealth.com
www.degenfelderhealth.com
310-740-0960

Financial/Operational Considerations for CHCs in Managed Care Contracting

Curt Degenfelder Consulting, Inc.

Timing

Medicaid managed care is going live in North Carolina 2/1/2020. Before the go-live date, community health centers should:

- Obtain contracts from most or all of the Medicaid managed care plans operating in your region
- Ensure that your patients choose the health center as their primary care provider (PCP)
- Understand how auto-assignment may assign new members to the health center, and determine what your responsibilities are for those members
- Understand the PPS wraparound system, and how the center will be made whole to your PPS revenue for all managed care visits
- Understand the Advanced Medical Home program

Keys for CHCs in Managed Care Contracting

In contracting with managed care organizations (MCOs), and in reviewing managed care contracts, community health centers should focus on the following areas:

- Contractual and legal obligations
- Financial considerations
- Administrative responsibilities

Please note that the issues covered in this training do not replace legal review. Managed care contracts are legally binding documents and thus should be reviewed by a qualified legal professional.

This presentation generally assumes that CHCs will be signing Primary Care Provider (PCP) contracts. In some cases, there may be different considerations for specialty or ancillary contracts.

Departments in an MCO

- Administration – contains the CEO, etc
- Provider Relations – primary interface with providers (may also be called Network Management). Focus is on maintain smooth relationship; typically have little operational authority.
- Contracting – have ability to change the contract. Also in charge of network adequacy
- Claims – responsible for paying (and denying) provider bills, also administer capitation
- Actuarial – develops premium rate request for MCO revenue. Develops fee schedules for MCO provider payments
- Member services – primary interface with members, including complaints.
- Legal
- Credentialing – responsible for checking credentials and verifying network participation
- Marketing/Enrollment – responsible for signing up members. May also handle auto-assignment
- Finance – in addition to internal, may monitor pay for performance

Financial & Operational Considerations

- Panel size
- Capitation – note that the reimbursement system will probably be fee-for-service
- Fee for service
- Services covered under capitation/fee for service visit rate vs. those services that can billed separately
- Copays/coinsurance/deductibles
- Timeliness of payment
- Wraparound
- Risk/surplus sharing

Contractual and Legal Obligations: Panel Size

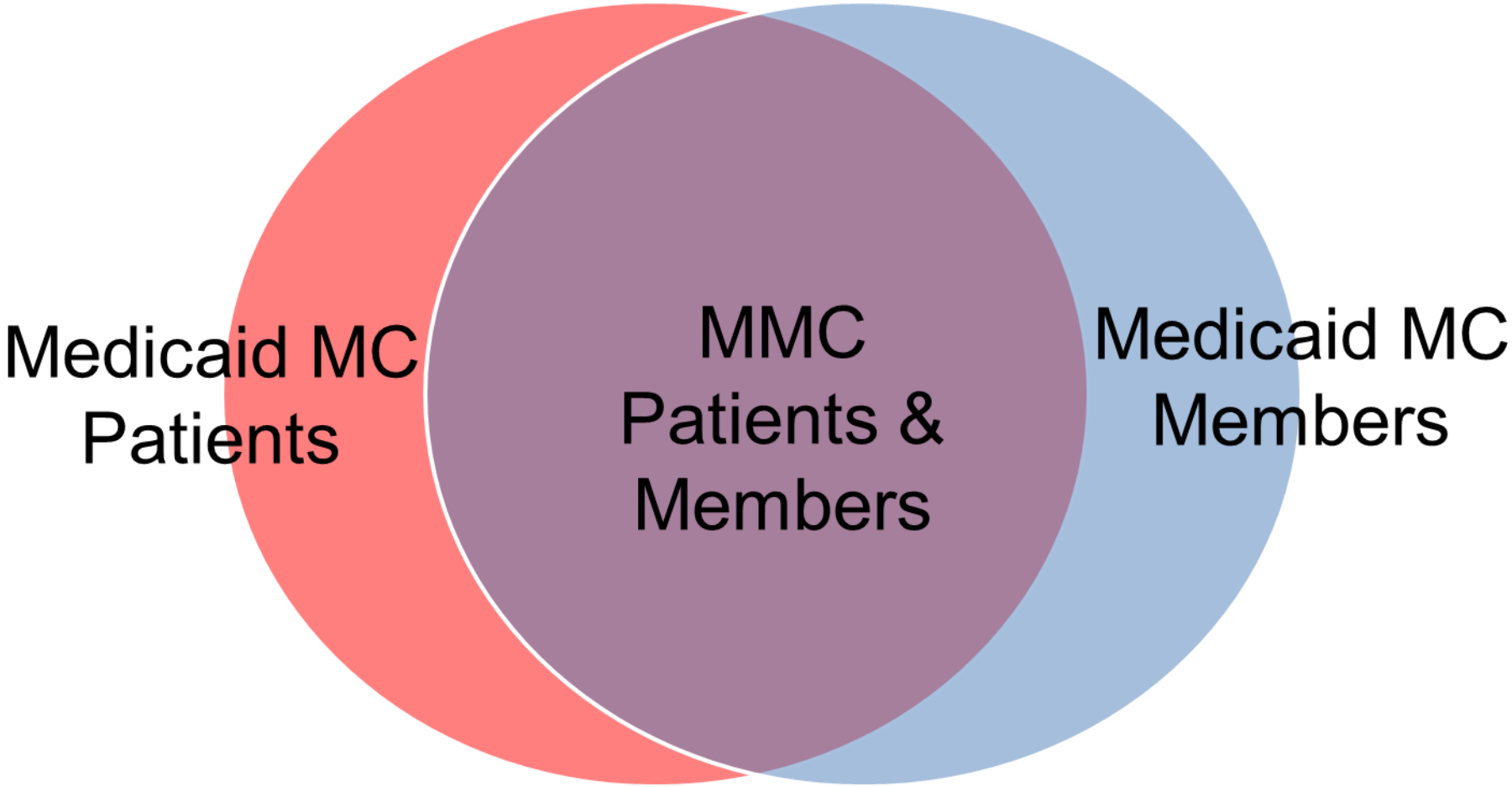
Panel size is the number of managed care members with the CHC as their primary care provider. This number will change each month, as members move in/out of the program, move in/out of the area, and add/drop the CHC as their primary care provider (PCP). Panel size considerations include:

- Minimum for capitation – the plans usually require a minimum number of members that must choose the CHC before it can be reimbursed on a capitated basis

- Closed panel – allows the CHC not to accept new patients from the plan. This may be useful for CHCs if panels can be closed by product line (i.e. not accept new commercial patients but continue to accept new Medicaid patients)

- Autoassignment – every plan member needs a PCP. Therefore, when members don't pick a PCP, they are assigned to one, whether or not they have seen that provider. Note that the demographic information for these members may not be accurate

Metrics from Autoassignment Models



Metrics from Autoassignment Models

Total Members	83,901
Members With A Visit	47,127
Members With A Service	48,653
Members with No Service	35,248
Assigned Not Seen Member %	42.0%
Assigned Not Seen Member Month %	37.6%
Total Visits	141,843
Member Months	774,051
Visits/12 Member Months/Year	2.20
Visits/Member/Year	1.69
Visits/Patient/Year	3.01

Financial Considerations: Fee-for-service

Fee-for-service can take two forms:

- Per visit rates – the MCO pays the CHC a flat per visit rate. This rate is rarely is the same as the health center's FQHC rate (see wraparound)

- CPT based fee schedule – the MCO pays the CHC based on a fee schedule that contains a reimbursement amount for each CPT code. This fee schedule is often based on RBRVS Relative Value Units (RVUs) and a fee schedule

It appears that in North Carolina, the plans will pay the health centers their core rate

Financial Considerations: Separately Billed Services

Capitated or per visit contracts should clearly delineate which services are included in the capitation or visit rate. They should also detail when the CHC is able to bill for services outside of the rate, and have a fee schedule for those services.

Financial Considerations: Copays/Coinsurance/Deductibles

Managed care plans often contain provisions whereby the patient is required to pay for a portion of their services. It is important to note that in developing these provisions, the MCO reduces the rates it would otherwise pay to the CHC. These provisions include:

- Copays – the patient is required to pay a fixed amount for a visit. For Medicaid plans, these are sometimes very small and less than the health center's minimum fee.

- Coinsurance – the patient is required to pay for a percentage of the total rate for the health center. A common non-managed care example of this is the Medicare 20% coinsurance.

- Deductible – the patient is required to pay a certain amount out of pocket before the MCO picks up costs. Primary care visits are sometimes exempt from deductible consideration.

Financial Considerations: Timeliness of Payments

In addition to the capitation example previously detailed, the contract should also include a provision for how quickly a “clean” claim – one that is eligible to be paid and contains no errors – will be paid. This timeframe is sometimes regulated by the state. Late payment by the MCO may result in penalties or interest, but these amounts are often very difficult for the CHC to collect.

Financial Considerations: Wraparound

The wraparound is a payment in a managed care environment to make up the difference between what the managed care plan paid and what the CHC would have gotten in fee-for-service environment. Wraparound originally came about in the BIPA legislation, and then was fully protected in the PPS legislation. Potential characteristics of wraparound:

- CHC bills the state directly for the difference for each visit, using the standard claim form.
- State pays the CHC a monthly or quarterly estimate based on managed care members; this amount is reconciled on an annual basis.
- CHC bills visits/report encounters to managed care organization (even for capitated services). MCO reports services to state; this report serves as basis for wraparound payment. CHCs have sometimes reported these arrangements to be problematic.

Financial Considerations: Advanced Medical Home Program

- Health plan center must attest to Tier 3 of PCMH

- Payment appears to be $3.50 PMPM

Questions:

- What have you attested to? What are you promising? How does the plan monitor?

- Can you provide all of the required services for $3.50 or less? Since you provide the same services to patients regardless of payor source, what is the total cost in your health center?

- Can you provide all of the service, or will you contract a portion?

Financial Considerations: Pay for Performance

MCOs allow CHCs to participate in pay for performance arrangements. In these arrangements, the CHC receives an extra payment if the MCO, or the MCO patients assigned to the CHC, achieve certain cost or quality goals. Key considerations include:

- Health plan quality measure is typically HEDIS, not UDS
- CHC risk – where possible, the CHC should avoid taking risk, (i.e. be contractually obligated to pay back or have funds withheld.)
- Pay for performance payments do not count in the wraparound calculation..

Many CHCs report that their plans' pay for performance plans are arbitrary, capricious, and rely on inaccurate data.

UDS vs. HEDIS – Sample

	Attributed Not Seen	Timely Entry Into Prenatal Care		Childhood Immunzation*	
		UDS	HEDIS	UDS	HEDIS
Health Center A	11%	74%	48%	68%	1%
Health Center B	11%	85%	66%	93%	0%
Health Center C	12%	86%	60%	84%	0%
Health Center D	9%	56%	53%	97%	1%
Statewide Administrative			59%		4.7%
Statewide Hybrid					64.7%

*Combination of Dtap, IPV, MMR, HiB, HepB, VZV, PCV

UDS vs. HEDIS – Sample

	Cervical Cancer Screening		Asthma Pharm Therapy	
	UDS	HEDIS	UDS	HEDIS
Health Center A	61%	47%	79%	84%
Health Center B	43%	72%	90%	84%
Health Center C	60%	66%	75%	86%
Health Center D	70%	69%	91%	92%
Statewide Administrative		66%		87%

Impact of Autoassignment on Pay For Performance

Well Child Exams in the First 15 Months of Life		
	HEDIS Score	
Overall Plan Performance	70%	
Required to Earn P4P Revenue	77%	
Health Center Performance		Patients
Plan Assigned Patients - Seen by CHC	80%	500
Plan Assigned Patients - Not Seen by CHC	70%	300
Total CHC Performance	76%	800

Operational Responsibilities

- Eligibility verification
- Billing requirements
- Reporting requirements
  - Encounter reporting
- Credentialing
- Provider Manual
- Referral/Utilization management/Quality assurance

Operational Responsibilities: Eligibility Verification

In order to the managed care organization to be obligated to pay for a service, the service in question needs to be:

1. For an MCO member that was eligible on the date of service
2. A covered service that can be billed for by the CHC, and
3. In a PCP environment, for a member who has selected the health center as their PCP.

Note that in North Carolina the member does NOT need to be assigned a PCP in order for the MCO to be required to reimburse the health center.

Operational Responsibilities: Eligibility Verification

Since these conditions may change frequently, the CHC should perform eligibility verification each time a member presents. Issues in eligibility verification include:

- The form of verification performed. While MCOs will often send the CHC a roster of eligible patients, the CHC is almost always contractually obligated to check eligibility electronically (via telephone, swipe card, or internet) on the date of service

- The contract should clearly state that whether or not this date of service verification guarantees payment if the MCO subsequently deems the member to be ineligible.

- Denied Medicaid managed care payments generally cannot be billed to other MCOs, nor can they by counted as self-pay patients for sliding fee/UDS consideration.

Administrative Responsibilities: Billing Requirements

Billing requirements generally include:

- Form(s) – generally the CMS 1500 or UB92 form.
- Electronic – some payors may require electronic submission, sometimes through clearinghouses
- HIPAA – privacy and security
- Timeliness – usually claims need to be submitted within 60 – 90 days of the date of service
- Preauthorization – generally not required for primary care services
- Denial rebilling – like the billing timeliness, denials must be rebilled/appealed within a certain timeframe

Operational Responsibilities: Reporting Requirements

Reporting requirements generally include:

- Quality reporting – potentially includes patient diagnosis and other health status indicators. May be supplemental to the claim file

- Complaint information – this frequently goes through the Plan's Member Services Department

Operational Responsibilities: Credentialing

Before contract execution, a representative from the MCO's Provider Relations Department may perform a site visit at the health center. Individual providers at the CHC must have the proper credentials, including:

- Provider information application
- State license
- DEA certificate
- Board certification
- Participating hospital admitting privileges
- Proper malpractice case history

If possible, contract should contain credentialing retroactivity clause (potentially to date that credentialing application is submitted) so that the health center is not providing free service based on the MCO's credentialing delays. CHC may also want to pre-credential providers, between their hire date and start date.

Operational Responsibilities: Provider Manual

MCOs should provide participating providers a provider manual that details the CHC's responsibilities. The MCO should also supply a provider directory, so that the CHC knows how to interact with the rest of the provider network. The provider manual could cover contractual items such as:

- Appointment standards
- Hours of operation
- On-call coverage
- Record keeping/retention
- Means of dispute resolution/arbitration

Operational Responsibilities: Utilization/Referral Management/Quality Assurance

Utilization and referral management, and QA responsibilities of primary care providers often include:

- Preauthorization protocols before admitting a patient to the hospital
- Inpatient rounding/discharge management protocols
- Referral forms and process required to send a patient for specialty or ancillary services
- Case management protocols (especially prenatal/post partum)
- Disease management protocols
- Reporting on MCO-wide quality initiatives

Contracting and Legal Considerations for CHCs in Managed Care Contracting

Contractual and Legal Obligations

- Contracting parties
- Term and termination
- Renewal
- Covered program/product lines
- Covered services
- Liability insurance
- Change in state and federal regulations
- Change in managed care organization ownership
- Terms to avoid

Contracting and Legal Obligations: Contracting Parties

A contract is a legally binding entity between two or more parties. In executing managed contracts, community health centers should recognize the following issues:

- The identity of all contracting entities. Potential issues include:
  - The managed care organization is a subsidiary of a larger organization. The contract should be clear, and the health center should understand, with which organization it is contracting
  - Potential subcontracted activities including utilization management or service offerings such as behavioral health or pharmacy. In these cases, the health center may need to sign a separate contract with the subcontracted entity. This has sometimes been problematic to health centers in the area of behavioral health, where the CHCs have been denied participation in the behavioral health provider network and thus have not been able to offer their patients their full service offerings.
  - Contract should be between the MCO and the health center, NOT with individual health center providers. An addendum should be attached to the contract that specifies the individual providers.

Contracting and Legal Obligations: Term and Termination

The contract is valid for a set period of time; and should clearly delineate this time period. The contract should contain language specifying reasons/timing for terminating the contract before its completion. There are typically two types of termination:

- **With cause** – means that the MCO or the CHC terminates the contract for a specific reason. Valid causes include non-performance by either side, non-conformance with contract terms, non-conformance with regulations. Contracts often specify a notification period for the termination, sometimes covering a period where the party may remedy its behavior.

- **Without cause** – means that a contractor may terminate the contract without a specific reason. This clause is not required; however, if the contract contains a clause for termination without cause for the MCO, it should contain a similar clause for the CHC.

Contractual and Legal Obligations: Contract Renewal

The optimal contract term, especially in the absence of a termination without cause clause, may be one year. This term will allow the CHC to exit a bad business deal, even if the MCO has not specifically done anything wrong. For administrative ease, many contracts include an “evergreen” clause, i.e. that the contract automatically renews each year if neither side terminates it.

Contractual and Legal Obligations: Covered Programs/Product Line

The CHC should protect itself by not allowing automatic participation in all of a managed care organizations product lines. These product lines could include:

- Medicaid
- SCHIP
- Medicare
- Commercial
- Workers compensation
- Tri-Care

Contractual and Legal Obligations
Covered Services

The contract should include a listing of covered services in at least two categories:

- Contract covered services – the contract should clearly state the set of covered services that the health center is expected to provide. Some Medicaid managed care plans may not include some Medicaid covered services (often dental and/or family planning), the CHC may continue to bill the State fee-for-service for these items.

- Capitation/visit rate covered services – these rates may not cover all services; the contract should clearly state what services (often specialty or ancillary) may be billed to the MCO on a separate fee-for-service basis

Contractual and Legal Obligations: Liability and Insurance

The managed care contract will specify what level of professional liability insurance the CHC must maintain; generally it is $1,000,000 (per incident)/$3,000,000 aggregate. FTCA is sufficient to cover these requirements.

The contract should also contain hold harmless provisions whereby the CHC is not liable for any of the MCOs actions (such as denying services).

Contractual and Legal Obligations: Change

Federal and state regulations governing the Medicaid & Medicare programs, managed care organizations, and community health centers are constantly changing. The contract needs to have two characteristics to protect the CHC:

- Flexibility – the contract must contain sufficient flexibility to allow the health center to operate within its regulatory guidelines. This is especially true for 330-funded health centers (such as the ability to offer sliding fee discounts for co-insurance/deductibles/copayments for commercial payments under 200% of the Federal Poverty Limit).

- Protection – the contract must offer protection to the CHC to ensure that it can continue to meet all its regulatory requirements

- Change in managed care ownership – the contract should contain a clause to allow the health center to exit the contract should the MCO be taken over by another organization

Contractual and Legal Obligations: Terms to Avoid

- "which may change from time to time" – this phrase gives the MCO the opportunity to change the contract term in question with impunity. Instead, the contract should state that the term can be changed with 30 days written notice to the health center, that the health center must agree in writing, and that if the health center does not agree the contract can continue unamended

- Vague terms (i.e. promptly, timely) – should be replaced by specific terms

- References to other documents – the Provider Manual, utilization management guidelines, quality assurance protocols, etc. – these references are acceptable. However, the CHC should consider the other documents part of the contract and should review them thoroughly before signing the contract. In addition, these documents cannot be changed without the CHC's assent (see first bullet)

Curt Degenfelder
curt@degenfelderhealth.com
www.degenfelderhealth.com
310-740-0960