Structuring Managed Care Contracts: Medicare and Medicaid Considerations for Providers
Navigating Reimbursement and Delegation Challenges, Negotiating Key Provisions and Anticipating Areas of Dispute

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Structuring Managed Care Contracts: Medicare and Medicaid Considerations for Providers

Navigating Reimbursement and Delegation Challenges, Negotiating Key Provisions and Anticipating Areas of Dispute
Overview

- Current Environment
- Key Contractual Provisions
- Governmental Contracting
- The Next Generation of Contracting
- Questions
Current Environment

- Move away from fee-for-services in certain cases
- Health Insurance Exchanges
- Accountable Care Organizations (ACOs) and other network building activities
- Cost and Quality Transparency and Reporting
- Data Sharing
Common Provider Frustrations

- Lack of leverage and resources to negotiate contract
- Payor insistence on “standard” contract
- Dealing with multiple contract components (manuals, web sites, etc.)
- Out of network disputes
Let’s Get Started!
DEFINITIONS
Key Definitions

- Clients and/or Payors
- Covered Services
- Medical Necessity
- Standard of Care
- Affiliates
PROVIDER OBLIGATIONS
Maintaining Records

- Uniformity across contracts
- Consistency with Federal and State law requirements
- HIPAA requirements
Audits

• Which party is responsible for audit costs?
• What documentation is subject to audit?
• Is the Payor required to provide advance notice?
• Are audit rights limited to a prescribed “look back” period?
• May the Payor use statistical sampling or extrapolations as a basis of an overpayment claim?
• Onsite audits - access
• Concurrent review
• Defining the scope of the audit
Policies and Procedures/Provider Manual

- Must modifications be provided to Provider in advance?
- Can the Provider object to modifications?
- In the event of a conflict, does the base agreement or the manual control?
- Access online
- Notice of changes
- Ability to terminate
Utilization Management

- Is the Provider’s right to appeal clearly delineated in the contract?
- Does the contract require Payor to respond to preauthorization requests within a specific period?
- Is the authorization an irrefutable verification of eligibility?
- Does the Payor maintain ultimate responsibility for decisions of medical necessity?
Claims Submission and Reimbursement

- Time Period and Process
- Obligation to Pay
- Nonpayment
- Retroactive Denial of Claims
- Coordination of Benefits
- Payment Based on a Percentage of “Then Current Fee Schedule”
OTHER PROVISIONS
Term and Termination

• Contract Term
  • Is the provider “locked-in” for a multi-year period?
  • Business reasons for being “locked-in” such as infrastructure investment

• Without Cause Termination

• For Cause Termination
  • Is there a cure period?
  • How much discretion does the Payor have to terminate “for cause”?

Term and Termination

- Transition Rights and Obligations
  - Transition of Care and Continuing Care Obligations
  - Communications to Members
- Dispute and Appeals
- Amendments to the Provider Manual
Insurance and Indemnification

- Insurance
  - Minimum amount
  - Proof upon request
  - Written notice of cancellation
  - Make mutual

- Indemnification
  - Often times one sided
  - Delete entirely
  - Modify to provide mutual protection
Other Provisions

- Amendments
- Assignment
- Changes in Law
- Governing Law
GOVERNMENT PAYORS
Key Issues for Medicare

• Freedom of Choice
• Compliance
• Testing the payment programs
Key Issues for Medicaid

• State programs
• Multiple chronic issues
Key Issues for Medicare Advantage

• Marketing rules
• Contracting provision
Government Enforcement

- Waste
- RACs
- Fraud and Abuse
- Sanctions
- Risk sharing laws
Payor Enforcement

• Using government enforcement as a model
• Others wanting to work together with providers
• Kicking out the bad apples
MOVING BEYOND TRADITIONAL CONTRACTING
Health Insurance Exchanges

- New product, often same payor
- Ability to terminate exchange product without terminating other products
- Require payor to be bound by confirmation of eligibility (pursuant to payor's mechanism)
  - No retroactive denial of payment for services rendered to individuals confirmed as eligible through such mechanism
Quality

- Public reporting
  - Hospital Compare
  - Physician Compare (coming soon)
  - Patient Surveys
- Qualified Entities
  - Appeals/Corrections
  - Selection of quality indicators
  - What is a good score?
  - Data
Cost Containment

- What is the relationship between Cost and Quality?
  - Pay for performance
- Why do we care now?
  - Aging of population
  - Tough economic times
- Shift in care setting
  - ACOs
  - Medical homes
  - Readmissions
Technology

**Telehealth**
- Virtual Care
- Telemedicine
- mHealth
- EHR implementation
  - Patient safety
  - Care coordination
  - Meaningful use
- Reimbursement not always there

**Data is King**
- Health plans have data and need data too
  - Some want to use it for quality
  - Focus on population management
  - Some willing to use it as a tool for providers
Questions

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