Ohio Association of Community Health Centers
Managed Care Contracting & Operations Issues
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Agenda/Goals For Today

- Managed care readiness
- Managed care operational issues
- Managed care contracting
General Thoughts on Medicaid Managed Care

- Managed care is a payment system.
- The primary goals of managed care are to reduce cost and provide greater control over the patient population and future cost.
- Health centers are already managing care. However, managed care efforts may or may not be consistent with current health center patient management efforts, PCMH, or meaningful use.
- Managed care is rational on a high level. The implementation of managed care may be totally irrational on a granular or operational level.
- The state may not wish to get involved with the relationship between a health center and a Medicaid managed care organization; part of their goal may be privatization and decentralization.
Operational Issues in Managed Care
Obtaining appropriate reimbursement in Medicaid managed care is more difficult than in Medicaid fee-for-service because:

- There is another organizational entity (i.e. the managed care organization) in addition to the State Medicaid agency
- The managed care organization may have its own set of rules
- States often take a “pay and chase” approach with Medicaid payments; in managed care claims are more likely to be denied upfront
- While in Medicaid managed care FQHCs are made whole to their PPS rate, additional effort is needed to go through the wraparound process – creating cash flow and potential revenue issues
Managed Care Readiness – Preparing for Day 1

The change from a Medicaid fee for service to managed care is often disruptive. In order for the system to function:

• The CHC will need to have contracted with the appropriate managed care plans. Health center will need to decide if it needs to contract with all Medicaid MCOs in its service area (and what to do with the MCO’s other product lines). *This is an important consideration now with the 5 statewide plans in Ohio, not all of which have previously operated in all 7 regions*

• The health center will need to be set up in the MCO’s system as the payee, and all CHC providers will need to be credentialled

• The patients will need to have signed up with the managed care plans and become members, and have their membership information (ID#, ID card)
Managed Care Readiness – Preparing for Day 1 (cont)

• If at all possible, CHC should educate its patients on MCO protocols
• CHC should have read through and understood the MCO’s Provider Manual
• CHC should have a list of all relevant MCO contacts
• The patients will need to have chosen the health center as their PCP OR have been assigned to the CHC
• Front desk and billing staff will need to be familiar with each MCO’s policies and procedures
Managed Care Readiness – Day 1

- Use MCO’s eligibility verification system
- Get PCP patient list
- Understand how to switch a patient to the CHC as a PCP
- *Prepare for potential chaos!* Potentially plan for the first few days of managed care as you would for a practice management or EHR implementation (e.g. lighter schedule, more management in the clinic space, etc)
Managed Care Readiness – Ongoing

• Who are your patients?
  • Patients you have seen (and may continue to see; CHC can get paid for these visits but administratively messy)
  • Patients assigned to you that you haven’t seen (they count against your HEDIS scores!)
• Reconciling MCO patient list, checking plan eligibility
• Working PCP change policy
• Billing policies, procedures, and locations for each MCO.
  **Timely reporting requirements**
Managed Care Readiness – Ongoing

- Record services and revenue for wraparound report; encounter reporting to MCO under capitation
- MCO’s appointment availability standards
- Behavioral health benefit limits
- What is the MCO’s ongoing QA oversight system:
  - Site reviews
  - Chart audits (may look at CPT and ICD coding)
  - Additional documentation/forms
Managed Care Readiness – Ongoing

- **Timely wraparound reporting**
- Determine percentage of PPS equivalent revenue that is coming from MCO billing (in many cases this is less than half of the total). The remainder is the cash flow deficit that the CHC will recover in wraparound
- Estimate revenue that can be earned through managed care incentive systems (and what may be required to earn it, like bringing in patients with certain conditions)
Managed Care Readiness – Ongoing - 2014

• Who are your patients who are eligible for Medicaid but are not enrolled?
• If Medicaid expands, and goes through managed care, can Ohio CHCs work with plans to create a rational patient assignment algorithm?
Managed Care Readiness – Ongoing - 2014

- Are we prepared to participate in shared savings?
  - What is the CHC’s total cost per Medicaid patient, vs the plan’s average?
  - What are key utilization indicators, such as inpatient days/1,000, avoidable readmissions, ER utilization?
  - What is the CHC’s risk profile – diagnosis based and psychosocial?

<table>
<thead>
<tr>
<th>Payments for Top 100 Most Expensive Patients</th>
<th>Annual per Member Cost</th>
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<tbody>
<tr>
<td>Rx</td>
<td>OP E&amp;M</td>
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<tr>
<td>CHC</td>
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<td>Plan</td>
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Managed Care Contracting
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.
Contractual and Legal Obligations

- Contracting parties
- Term and termination
- Renewal
- Covered program/product lines
- Covered services
- Reciprocity
- Liability insurance
- Change in state and federal regulations
- Change in managed care organization ownership
- Panel size/status
- Contract changes – terms to avoid
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.
Contractual 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. Specific considerations (especially for FQHCs and look-alikes) include:

- Medicaid (and supplemental family programs as applicable) – include wraparound to PPS or alternative methodology visit rates. Thus they key bottom line (as opposed to cash flow) impact of these contracts may be the inclusion of risk/surplus sharing provisions (which are not included in the wraparound calculation). Medicaid is funded by both the federal government and the state, and follows federal minimum guidelines and state rules.

- SCHIP – is now paid at the PPS rate (so there will be wraparound).
Contractual and Legal Obligations
Covered Programs/Product Line (continued)

The CHC should protect itself by not allowing automatic participation in all of a managed care organizations product lines. Specific considerations (especially for FQHCs and look-alikes) include:

- Medicare – the Drug, Improvement, and Modernization Act established wraparound for Medicare Advantage (formerly Medicare Plus Choice) patients. After initial confusion, it appears that UGS may have Medicare wraparound functioning. In order for the FQHC to receive wraparound, the Medicare Advantage contract may require specific language stating that the FQHC is paid at a rate at least equal to other providers. Medicare is totally federally funded and follows federal rules. Medicare/Medicaid dual eligibles will be partially funded by the state.

- Commercial/no-fault/Tricare/workers’ compensation – no wraparound is available, the CHC has the most incentive to maximize payments in these categories
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
Reciprocity
The contract may include a reciprocity provision that states that the CHC is obligated to provide services for patients from other MCO service lines or service areas. The reimbursement rates should be at least equal to what the CHC receives for patients directly covered under the contract.
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 in State and Federal Regulations

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 of 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

Panel Size

Panel size is the number of managed care members that have chosen 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 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)
Contractual and Legal Obligations

Contract Changes – 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).
Financial Considerations

- 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
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 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
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. Examples of such services could include:

- Deliveries, and/or maternity costs (e.g. fetal stress tests)
- Lab
- Radiology
- Pharmacy
- Behavioral health (a separate organization may be in charge of administering managed behavioral health)
- Immunizations/vaccinations
Financial Considerations
Copays/coinsurance/deductibles

Managed care plans often contain provisions whereby the patient is required to pay for a portion of their services (these are sometimes limited by state Medicaid rules). 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
Risk/Surplus Sharing

MCOs sometimes allow CHCs to participate in risk or surplus sharing arrangements. In these arrangements, the CHC receives an extra payment if the MCO, or the MCO patients assigned to the CHC, achieve certain medical loss ratio or profitability goals. Key considerations in these arrangements include:

- CHC risk – where possible, the CHC should avoid taking risk, i.e. be contractually obligated to pay back or have funds withheld. If the CHC enters into a risk arrangement, it should:
  - Take risk only for its own members, not for all plan members
  - Have a stoploss/risk corridor arrangement to limit its downside. CMS limits risk downside to 25% of payments; the CHC should establish a lower threshold.

- Risk/surplus sharing payments do not count in the wraparound calculation. These payments do not require an actual transfer of risk in order to be exempt from the calculation.

- Administrative and management add-ons do count in the wraparound calculation, and this provider mainly only cash flow advantages.
Administrative Responsibilities

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

Since these conditions may change frequently, the CHC should perform eligibility verification each time a member presents (and for that matter, each time a non-managed care Medicaid patient 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
Administrative Responsibilities
Reporting Requirements

Reporting requirements generally include:

- Encounter reporting – to get utilization data in capitated contracts
- Quality reporting – potentially includes patient diagnosis and other health status indicators
- Complaint information – this frequently goes through the Plan’s Member Services Department
Administrative Responsibilities
Credentialing

Before contract execution, a representative from the MCO’s Provider Relations Department may perform a site visit at the health center. In addition, the contract may contain language about maintenance of the facility, and patient/worker safety policies and procedures. In addition, the 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
Administrative 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
- Advance directives
- Record keeping/retention
- Means of dispute resolution/arbitration
Administrative 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