Managed Care Contracting for Indiana Association for Home & Hospice Care
Susan E. Ziel, RN JD Krieg DeVault LLP

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Objectives
- Managed Care Stakeholders
- Applicable Requirements Governing Managed Care Contracting
- Key Terms in a Managed Care Contract
- Indiana Managed Care
  - Commercial
  - Medicare Advantage Plans
  - Medicaid Managed Care
Managed Care Stakeholders

- Enrollee
- Provider
- Integrated Health System
- Provider Contracting Network
- Managed Care Organization (MCO)

Enrollee

- Individual who participates in a MCO plan and receives health benefits either by way of direct contract or by virtue of employment

Provider

- Health care provider who provides items or services to an enrollee
  - As a contracted provider with MCO (or)
  - As an out-of-network provider for services that are covered by contract with a MCO
Integrated Delivery System

- A joint effort on the part of multiple health care providers to contract with a MCO to provide a menu of health care services to enrollees
  - Single legal entity vs. affiliations
  - Efficient and unified organization
  - Enhanced market competition

Provider Contracting Network

- An entity consisting of independent health care providers primarily organized for purpose of contracting with MCO

Managed Care Organization

- Health Maintenance Organization (HMO)
  - Combines delivery and financing of health care services on a prepaid basis
- Preferred Provider Organization (PPO)
  - Insurance plan utilizing a roster of preferred health care providers which, if used by enrollee, results in reduced coinsurance or deductible amounts to enrollee
Applicable Requirements Governing Managed Care Contracts

- Laws and Regulations
  - Antitrust laws
  - Indiana Insurance laws
    - IC 27-8-11-3 ("Any willing provider")
  - Contract laws
- Payor Requirements
  - Commercial
  - Government
    - Medicare Advantage Plans
    - Hoosier Healthwise; Care Select

Key Terms in a Managed Care Contract

- Verification of Enrollment and Current Coverage
- Covered Services
- Prior Authorization
- Medical Necessity
- Quality and Utilization
- Clean Claim
- Coordination of Benefits
- Exclusivity
- Referrals
- Compensation
- Most Favored Nation Clause
- Appeals
- Amendments

Verification of Enrollment and Current Coverage

- Membership cards
- Enrollee databases
- Telephone verification
- Services rendered in reliance on MCO verification
- Time sensitive
Covered Services

- Basic services covered and available to enrollees under MCO plan
- Description of covered services must match services delivered by provider
- Roster of covered services attached to contract (or published)

Prior Authorization

- Certification process required before provider renders services to enrollees
  - Covered enrollee
  - Covered services
- Emergency service exception
- Time sensitive

Medical Necessity

- Those covered services that MCO will pay for with respect to
  - A particular patient
  - A particular diagnosis or condition
- Although a service may be covered, it may not always be medically necessary
Quality and Utilization

- MCO monitoring of services rendered by contracted providers
- Quality and medical necessity standards
- Non-compliance resulting in exclusion from contract
- Due process rights
- Quality/UR plans attached to contract (or published)

Clean Claim

- Definition
- Assurances of payment for clean claim
- Indiana “prompt pay” laws administered by Indiana Department of Insurance

Coordination of Benefits

- Clarify which benefit plan must pay first in the event of dual coverage
- MCO versus provider responsibility to coordinate benefits
Evergreen Clause

- Clause provides for automatic renewal of contract
- Include other termination provisions
  - 90 days prior to renewal date
  - By agreement
  - Without and with cause
  - Immediate termination

Exclusivity

- Two scenarios
  - Provider may contract only with MCO
  - MCO designates provider as the other contracted provider of the MCO
- Careful attention due to antitrust (among other) risks

Referrals

- In network versus out-of-network
- Independent medical judgment
- Availability of qualified providers within network
- Financial penalties
Compensation

- Prepaid, per capita payments
- Prepaid, aggregate, fixed sum payments
- Discounted fee-for-service payments
- Other

Most Favored Nation Clause

- Requires provider to treat MCO no less favorably than it does any other MCO
  - Discounts or other reduced rates

Appeals

- The review of a denial or other adverse decision by an MCO
  - Usually a multi-step process
  - In-house versus independent reviewers
  - Time sensitive
  - If MCO is an HMO, certain appeal rights required by Federal laws
Contract Amendments

- Amendments
  - Prior express written agreement of parties to contract
  - Prior written notice of amendment 90 days in advance
  - Published notice of amendments
  - Other

Persistent Issues

- Medicare Advantage Plans
  - 42 CFR 422.214 (Special rules for services furnished by non-contract providers)
  - Provider subcontracts with IDS or other health care providers
  - Other

Questions?

Susan E. Ziel, RN JD
Krieg DeVault LLP
12800 N. Meridian; Suite 300
Carmel, IN 46032
(317) 238-6244
sziel@kdlegal.com
www.kriegdevault.com
Questions?
Susan E. Ziel, RN JD
Krieg DeVault LLP
12800 N. Meridian; Suite 300
Carmel, IN 46032
(317) 238-6244
sziel@kdlegal.com
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