Noon Briefing:
Refresher on the Basics of Managed Care Contracting

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Refresher on the Basics of Managed Care Contracting

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Speaker

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Background

- June 2018: Aetna Better Health of Kansas was announced as a Medicaid managed care organization (KanCare) – replacing Amerigroup.
- Kansas hospitals will be presented with managed care contracts or amendments to existing contracts.
- An opportune time to brush up on contracting principles generally and nuances of managed care contracts.

Our Goals

- Develop an approach for reviewing managed care contracts, including a list of specific parts of the contract on which to focus.
- Identify the leverage (or lack thereof) available to hospitals in their negotiation of managed care contracts.
- Develop a strategy for negotiating managed care contracts leading to better terms and fewer surprises for hospitals.
- Remain mindful not to engage in conduct that might be viewed as anti-competitive.

Simple Truths About Contracts

- What is a contract? A summary of the terms of a business arrangement between two or more parties.
- Litmus test for a well-written contract: The terms are clear to someone not familiar with the arrangement.
- Contract review is tedious work, but it must be done to protect the hospital.

Simple Truths About Contracts

- Key provisions of a contract are those that impact, directly or indirectly:
  - Money
  - Duties
- Each contractual right must have:
  - A process to enforce it; and
  - Penalties to protect it.
- A contract is only as good as your willingness to enforce it.

Reviewing Managed Care Contracts – Three Principles

1. Create Certainty
2. Answer Core Questions
3. Understand Key Terms

Reviewing Managed Care Contracts

Principle 1 – Create Certainty

- Parties can transact business without a contract.
- But, lack of a contract creates uncertainty
- Societal norms dictate terms of some non-contractual business arrangements – *e.g.*, payment for food eaten at a restaurant
- However, most arrangements (such as managed care contracts) require the parties to negotiate terms – *i.e.*, create certainty

Reviewing Managed Care Contracts

Principle 2 –Core Questions to Be Answered by Managed Care Contracts:

- What services is the hospital expected to provide?
- For whom is the hospital expected to provide such services?
- How much will the hospital be paid for performing such services?
- What steps is the hospital required to take in order to be paid for such services?
- What rights does the hospital have (against the managed care plan or against the patient) if the managed care plan does not pay the hospital for such services?

Reviewing Managed Care Contracts

Principle 3 – Understand the Terms of the Managed Care Contract that Affect:

- The services the hospital is required to provide.
- The people for whom the hospital will provide the services.
- The amount the hospital will be paid for providing such services.
- The steps the hospital must take to be paid for such services.
- The rights the hospital has if the managed care plan does not pay for such services.

Note: It is not always obvious which contract provisions address each of these aspects of a managed care contract.

Key Aspects of Managed Care Contracts

- Definitions
- Services provided by hospital
- Pre-authorization
- Identifying members/beneficiaries under a given contract
- Identifying who is a covered person
- Determining the amount payable for a covered service
- Billing and payment processes
- Enforcement provisions
- Term and termination
- Provider handbooks and other policies and procedures
- Exhibits, attachments, and addenda

Key Aspects – Definitions

Definitions directly impact:

- The services to be provided, for example:
  - “Covered Service”
  - “Non-Covered Service”
  - “Emergency Service”
  - “Medically Necessary”
- The people to whom services are provided, for example:
  - “Covered Person”
  - “Customer”
  - “Member”
  - “Insured”
  - “Beneficiary”
  - “Benefit Plan”

Key Aspects – Definitions

Definitions directly impact:

- The amount paid, for example:
  - “Customary Charge“
  - “Covered Amount”
- The steps to obtain payment, for example:
  - “Clean Claim”
  - “Provider Manual”
  - “Payment Policy”
  - “Protocol”
  - “Member Expenses”

Key Aspects – Definitions

- The Hospital's remedies for non-payment, for example:
  - "Provider Manual"
  - "Payment Policy"

Important: Often, one or more defined terms are imbedded within another defined term. So it is often necessary to explore and understand several terms just to define another one.

Key Aspects – Services

Regarding services to be provided/paid for, consider:

- Description of services
  - General description?
  - In a listing?
  - Prescribed by statute or regulation?
- Excluded services
  - General description?
  - In a listing?
- Medical Necessity:
  - Is it defined?
  - What services does it include/exclude?
- Payment for excluded services (if any).
- Payment for new or experimental services?

Key Aspects – Pre-Authorization

Regarding the process for obtaining pre-authorization, consider:

- What services require pre-authorization?
- What is the process for pre-authorization?
- Can the MCO withdraw authorization after it has been given?
  - If so, under what circumstances?
- Medical Necessity:
  - What role does medical necessity play in pre-authorization?
  - How is medical necessity defined?

Key Aspects – Identifying Members/Beneficiaries

Regarding who is covered under the contract, consider:

- What kinds of products does the MCO offer?
  - Traditional health insurance? PPO/POS products? HMO? Medicare Advantage? KanCare? Network rental product?
  - Each may be sold to unique customers to cover a unique set of individuals.
- Regarding the contract under review:
  - Is it an addendum to an existing contract? If so, what type?
  - Does the underlying agreement call for opt in or opt out?
  - Does the new contract/addendum purport to provide services to beneficiaries of existing contracts?
  - Can additional products be added to the contract under review?
  - Can the MCO roll beneficiaries of a newly acquired plan into the contract under review? Or, conversely, shift covered persons from the contract under review to a plan acquired in the future?

Key Aspects – Who Is a Covered Person?

Regarding identification of covered persons, consider:

- Means of identification:
  - ID card?
  - Other?
- What must the hospital do to verify covered person?
  - Real-time verification?
  - Digitally or otherwise?
- Medical Necessity:
  - Is it defined?
  - What services does it include/exclude?
- Which party bears the financial risk of incorrect identification as a covered person?
- Does financial risk depend on the cause of the misidentification?

Key Aspects – Amount Payable

Regarding the amount payable for covered services, consider:

- Is the amount fixed (*i.e.*, a fee schedule) or a formula (*e.g.*, a percentage of charges)?
- If it's a formula?
  - Is it clearly articulated?
  - What are the variables? How are they defined?
- Can the fee schedule or formula be changed during the term of the contract? If so, why/when and how?
- What is the hospital's recourse if the fee schedule or formula changes (*e.g.*, early termination)?
- If the MCO has multiple products, does the same fee schedule/formula apply to all products or does each product have a separate fee schedule/formula?

Key Aspects – Billing and Payment Processes

Regarding billing and payment for services, consider:

- How does the hospital submit claims?
  - What forms/format?
- What is the time frame for claims submission?
- What is the consequence for late claims?
- What is the time frame for the MCO to process the claim?
- What is the consequence for late claim processing/payment?
- What is the hospital's recourse for claims that are not paid or are incorrectly paid?

Key Aspects – Enforcement Provisions

Regarding contract enforcement provisions, consider:

- Choice of law provision
- Choice of venue/forum provision
- Equitable relief provision
- Alternative dispute resolution provisions (for example, mediation and/or arbitration)
- Provision for payment of attorneys' fees and costs

Key Aspects – Term and Termination

Regarding term and termination of the contract, consider:

- The length of the term
- Any automatic renewal?
- The right to terminate the contract:
  - Without cause
  - With cause
  - Other reasons – *e.g.*, change in fee schedule/formula, change in handbook or policies, etc.
- Penalties or other contractual rights in connection with termination
- Rights and responsibilities upon termination – *e.g.*, continuity of care

Key Aspects – Handbooks, Policies, Procedures

Regarding extra-contractual obligations, consider:

- The MCO's Provider Handbook, policies, and procedures (collectively, "Policies") often contain many substantive obligations.
- Does the contract require the hospital to comply with the Policies?
- Does the contract give the MCO the ability to modify the Policies unilaterally?
- Are there any limitations on the MCO's ability to modify its Policies?
  - Is advance notice of modification required?
  - Does the hospital have the opportunity to object? If so, what recourse is available? *E.g.*, no modification? Early termination?
- If the contract requires the hospital to comply with the Policies, then the Policies must be reviewed with the same level of scrutiny as the contract itself.

Key Aspects – Exhibits, Attachments, Addenda

Regarding extra-contractual obligations, consider:

- Exhibits should receive the same level of scrutiny as the underlying contract.
- Are the exhibits referenced in and/or incorporated by reference into the contract?
- Exhibits to the contract may:
  - Merely provide more detail about concepts in the underlying contract
  - Insert new terms and concepts not discussed in the contract
  - Insert alternative terms that replace terms in the contract
  - Insert alternative and additional terms for a specific managed care product

Leverage

- A party's ability to negotiate the terms of a contract depends on how much leverage the party has.
- A hospital's leverage to negotiate a managed care contract might arise from:
  - The hospital's reputation or standing in the community (enhancing the MCO's network)
  - The hospital's unique capabilities of providing services that are in high demand
  - Network adequacy requirements dictate inclusion of the hospital in the MCO's network
  - The hospital's provision of high-quality/low-cost services

Leverage

- In addition to enhancing their own services to obtain the leverage described in the preceding slide, hospitals have engaged in the following efforts to enhance their leverage with MCOs:
  - Participation in a Physician Hospital Organization (PHO)
  - Participation in an Independent Provider Association (IPA)
    - Messenger Model
    - Clinically Integrated
  - Participation in an Accountable Care Organization (ACO)
    - Medicare
    - Commercial
  - Affiliation or merger with a larger hospital/health system
  - Participation in new reimbursement models

Avoid Anti-Competitive Behavior

- Competing providers must be mindful of, and avoid, activities or sharing of information that might be viewed as anti-competitive.
- Price information is particularly sensitive. Competitors should not share price or cost information except as permitted by the FTC/DOJ Guidelines.
- Competitors should not engage in group boycotts, collective refusals to deal, agreements to divide or allocate the market, or other unfair trade practices.
- Refrain from discussions (whether formal or informal) that might be construed as such.

Strategy for Review of Managed Care Contracts

1. Identify a team representing affected areas of the hospital – *e.g.*, finance, IT, billing, clinical.
2. Team reviews the terms of the contract.
3. Each team member identifies potentially problematic terms.
4. Team identifies the relative leverage of the hospital and the MCO.
5. Identify contract terms the hospital wants to change.
6. Prioritize the proposed changes in order of importance and likelihood of change (given the hospital's leverage).

Strategy for Review of Managed Care Contracts

7. Team members identify alternative terms for the problem provisions identified.
   - Be creative – not every issue is a zero-sum game.
   - Consider the impact of proposed changes on the MCO.
   - There is often more than one way to improve upon a particular provision, so try to identify multiple alternatives.
   - If possible, identify approaches for change that protect the hospital, but minimize the impact on the MCO.

Strategy for Negotiating Managed Care Contracts

1. Identify a subset of the team to be directly involved in negotiating the terms of the contract.
2. Meet/communicate with the MCO representatives to discuss/negotiate the managed care contract.
3. Communicate MCO's responses/proposals to relevant team members for evaluation and input.

Questions

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