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Managed Care Community of Practice

Contracting with Managed Care Plans

October 29, 2018

Agenda

- **SIP-PL Transition**
- **Introduction to Managed Care Contracting**
- **Key Considerations for Contracting with Managed Care Plans**
  - Provider Credentialing
  - Utilization Management
  - Provider Compensation
  - Claims Submission and Billing
  - Audit and Oversight
  - Indemnification and Insurance
  - Assignment and Amendments

Specialized I/DD Plans – Provider Led (SIP-PL) Transition

Projected Timeline for Managed Care Transition

Key Events	Anticipated Date
Release of Final OPWDD Managed Care Requirements and Standards and Application	November 2018
Deadline for Plan Submission of Applications to New York State	February 2019
State announces approved SIPs-PL	June 2019
SIPs-PL begin to enroll individuals with I/DD downstate voluntarily	August 2019
SIPs-PL begin to enroll individuals with I/DD in the rest of State voluntarily	2020
Expansion to Mandatory enrollment begins for individuals with I/DD beginning Downstate and moving to rest of State	2021-2022

Introduction to Managed Care Contracting

Managed Care Contracting 101

Managed care plans must build a network of providers that is sufficient to serve their members and that complies with network adequacy standards that are set by the State.

Providers can enter into two types of contracts with managed care plans

Network Contracts

Agreements by which providers agree to serve **all or any of the plan's members**

Single Case Agreements

In cases where a provider is not participating in a plan's network, the provider may still enter into a single case agreement under which the provider agrees to serve **a single beneficiary** in order to:

1. Preserve continuity of care; or
2. Fill a gap in the network

Today's focus

Common Components of Health Plan Contracts

Define Responsibilities of Each Party

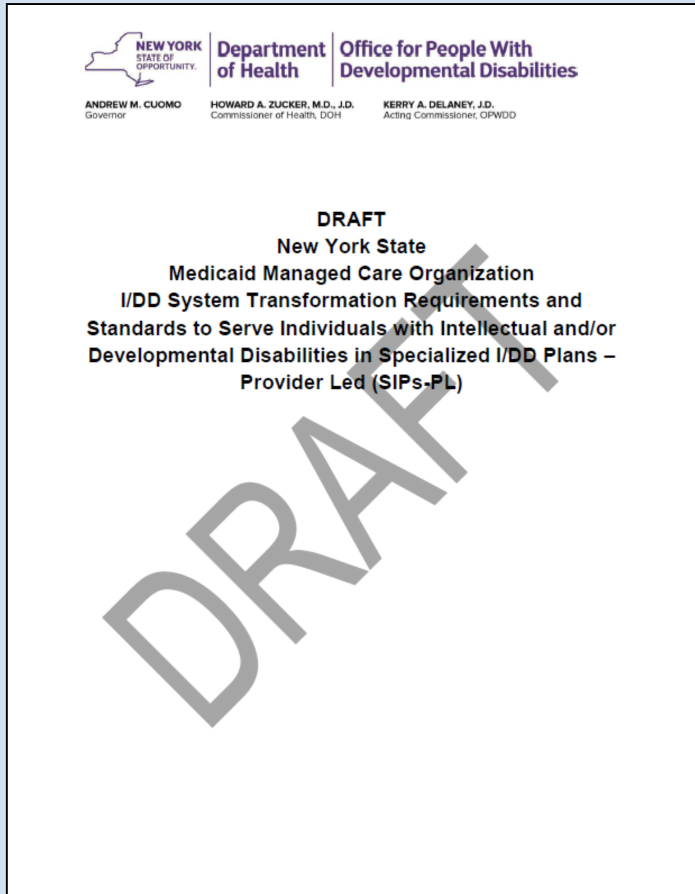
- **Provider responsibilities** (e.g., services, requirements applicable to those services)
- **Plan responsibilities** (e.g., payment to providers)

Describe Standards and Requirements

- Provider credentialing
- Utilization management
- Provider compensation
- Claims submission and billing
- Indemnification and insurance
- Audit and oversight
- Assignment and amendments

Required Components of Health Plan Contracts

New York State Office for People With Developmental Disabilities (OPWDD)


NEW YORK STATE OF OPPORTUNITY. | Department of Health | Office for People With Developmental Disabilities

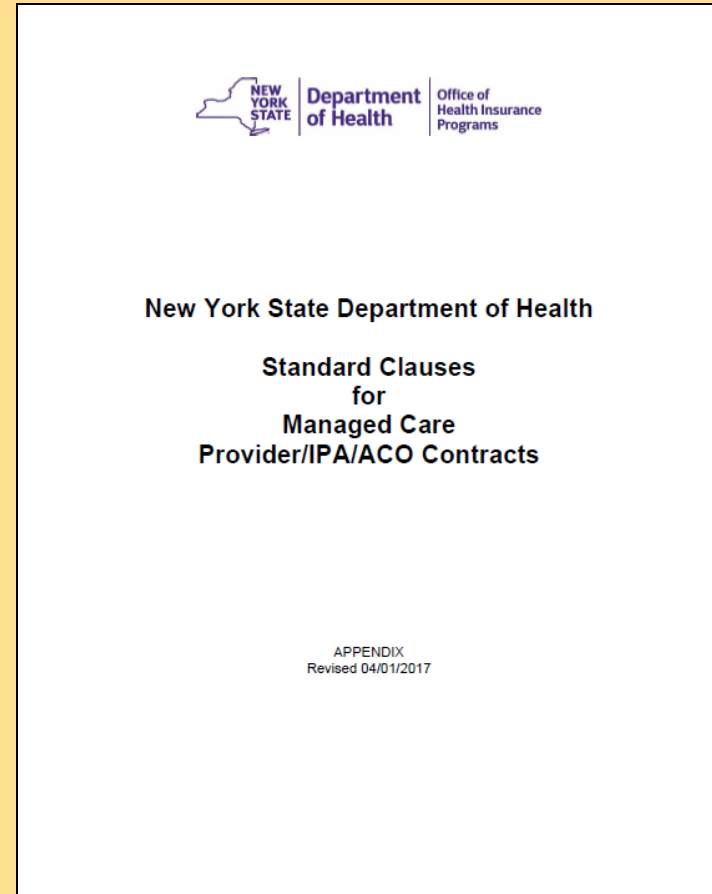
ANDREW M. CUOMO, Governor
HOWARD A. ZUCKER, M.D., J.D., Commissioner of Health, DOH
KERRY A. DELANEY, J.D., Acting Commissioner, OPWDD

DRAFT
New York State
Medicaid Managed Care Organization
I/DD System Transformation Requirements and Standards to Serve Individuals with Intellectual and/or Developmental Disabilities in Specialized I/DD Plans – Provider Led (SIPs-PL)

DRAFT

A final version is anticipated in November 2018

New York State Department of Health (DOH)


NEW YORK STATE | Department of Health | Office of Health Insurance Programs

New York State Department of Health

Standard Clauses
for
Managed Care
Provider/IPA/ACO Contracts

APPENDIX
Revised 04/01/2017

Key Considerations for Contracting with Managed Care Plans

Provider Credentialing

Managed care plans are required to credential all participating providers.

At the time of contracting and again at least once every three years, the plan must:

- Validate all credentialing requirements
- Search for medical sanctions by DOH and/or Medicaid
- Search the National Practitioners Data Bank

How It Works

Provider Application

is sent to the plan and triggers...

Credentialing Process

Non-delegated

- Gather all documentation
- Attestation/paperwork
- Review all provider's records

If there is history of malpractice or sanctions, a Medical Director will review, and the process may take longer.

Primary care providers may be subject to an office inspection by the plan.

Delegated

Plans may use a "delegated" approach with hospitals and larger organizations that use their own credentialing oversight.

Credentialing Committee Review

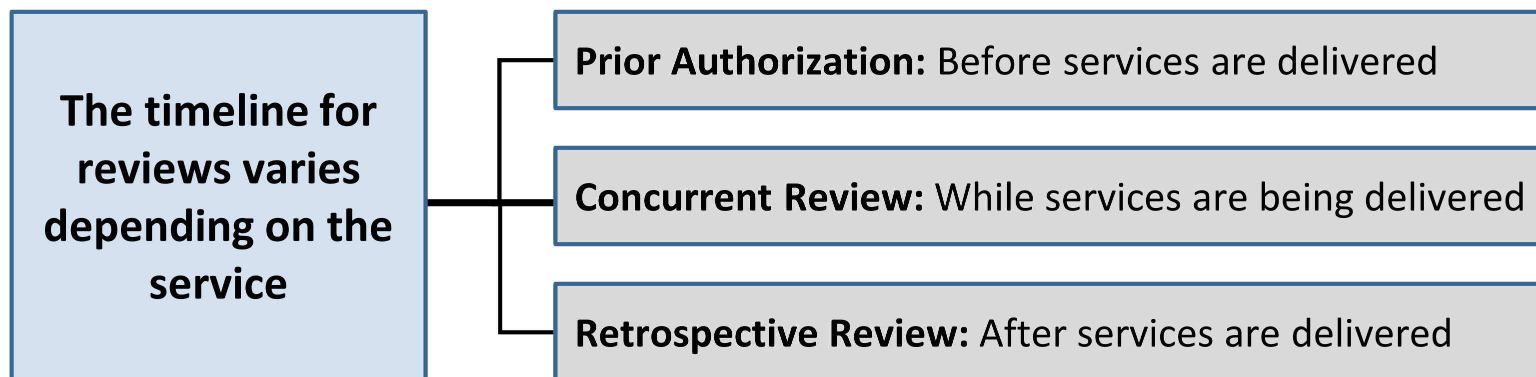
With approval from committee, a provider is approved.

The draft SIPs-PL Requirements and Standards document requires that plans accept OPWDD certification of providers for credentialing purposes. Plans would not be allowed to separately credential individual staff members in their capacity as employees of the program.

Utilization Management (UM)

Managed care plans evaluate the appropriateness of new and ongoing services based on medical necessity criteria.

- While UM criteria generally vary by plan, DOH and OPWDD are likely to establish UM criteria for most, if not all, services that plans must adhere to.
- Utilization reviews are typically completed by nurses and overseen by the health plan medical director.
- If a service is denied, providers and members may appeal the decision. Health plans must share a written description of the plan's utilization review policies and procedures as well as guidance for appealing an adverse determination.



The Life Plan developed by the member's Care Coordination Organization (CCO) will be key in authorizing OPWDD Home and Community Based Services (HCBS).

The draft SIPs-PL Requirements and Standards require that the SIPs-PL and CCO collaborate to maintain the individual's Life Plan.

Provider Compensation

Managed care plan contracts must specify the payment rates for services.

- The State will likely set benchmark rates for the first few years following the transition.
- Prompt pay laws require that claims be paid within 30 days of receipt of electronic claims and within 45 days of receipt of paper claims.

To protect providers in the event of eligibility systems errors, plans should include a provision that ensures the provider will be paid as long as the provider confirmed eligibility with the plan at the time of service.

Claims Submission and Billing

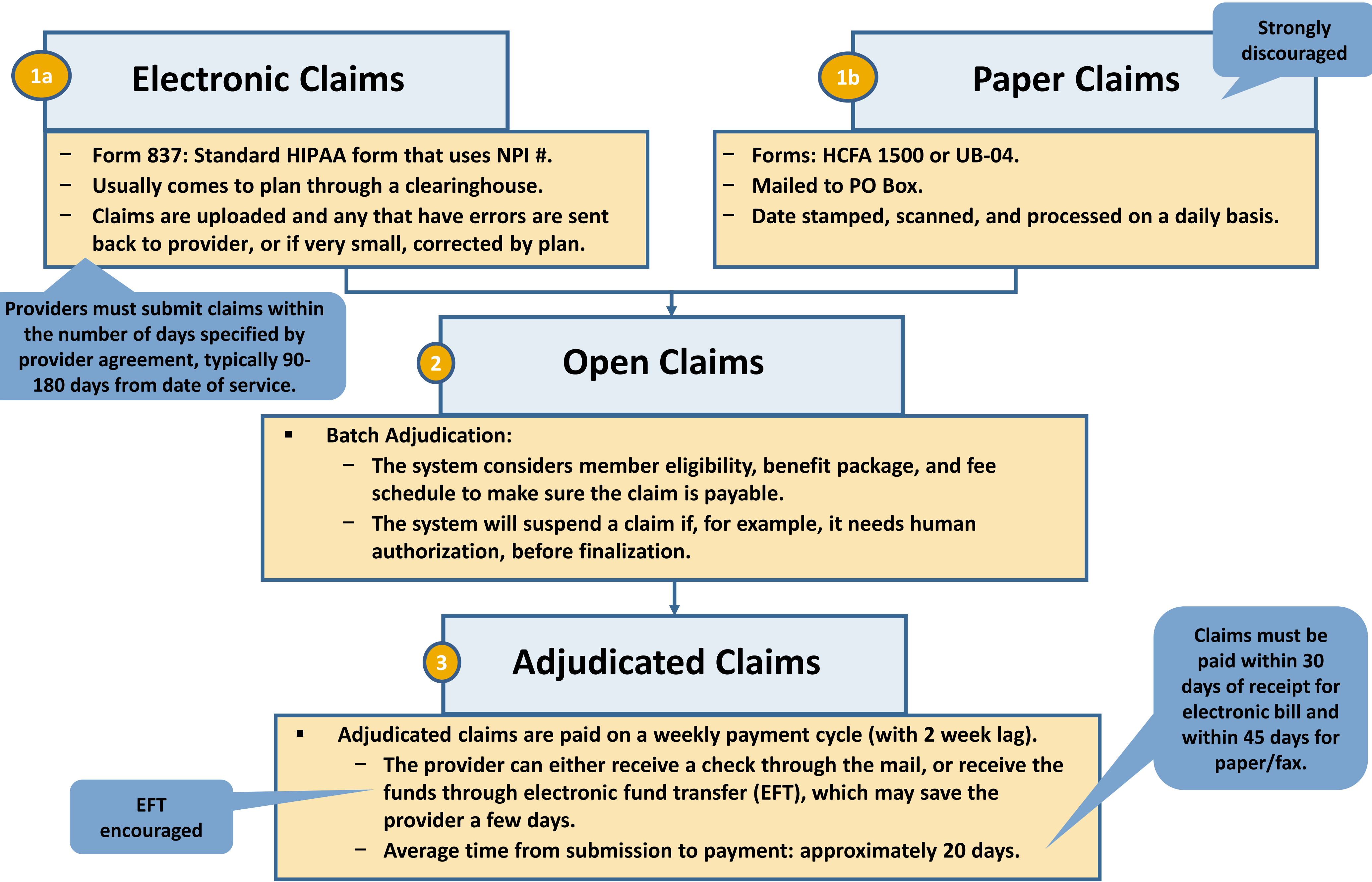
Managed care plan contracts describe how providers will bill for services.

Provider Responsibilities

- Understand what information is required to submit a claim
- Ensure electronic claims submission is feasible
- Engage in claims testing with plans prior to billing services
- Submit "clean claims" within the required timeframe*

**State law provides for at least 120 days for providers to submit claims, but managed care plans are permitted to contract for as few as 90 days.*

Overview of Medicaid Managed Care Claims Process



Audit and Oversight

Health plans and government agencies may perform audits of providers to ensure quality care.

New York State Department of Health

Standard Clauses
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APPENDIX
Revised 04/01/2017

The Standard Clauses require that documents be maintained for six years, but the State is moving toward a 10-year retention period.

- Providers may wish to negotiate limitations on a health plan's audit rights to ensure that audits do not impede business operations (e.g., requiring a specific number of days' prior notice, limiting audits to once per year). The State's audit rights cannot be limited.

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New York State
Medicaid Managed Care Organization
I/DD System Transformation Requirements and
Standards to Serve Individuals with Intellectual and/or
Developmental Disabilities in Specialized I/DD Plans –
Provider Led (SIPs-PL)

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The SIPs-PL Requirements and Standards require plans to set quality standards.

- Plans must be able to monitor provider performance and impose corrective actions and/or sanctions if the provider does not satisfy quality standards.

Indemnification and Insurance

Managed care plan contracts will require providers to have insurance and are likely to specify the minimum amount.

- **Indemnification:** In the event one entity is sued as a result of negligence on the part of another entity, the entity responsible must provide compensation.
  - In other words, if an employee or agent of your organization does something negligent and the plan is sued, the plan can seek compensation from your organization.
- Contracts will require that the provider indemnify the plan and the plan indemnify the provider.

Assignment and Amendments

Managed care plan contracts will include specifications for amendments.

- The contract should require amendments to be in writing and be signed by both parties.
  - *This will ensure that the plan does not attempt to unilaterally amend the contract.*
- The contract should allow the provider to assign the contract in the event that the provider chooses to sell or merge the practice.

Questions

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