Legal Issues in Agreements Between Behavioral Health Providers, Health Homes and MCOs

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Road Map

1. Overview
   - Types of Insurance and MCO Obligations
   - Regulators

2. Types of Agreements
   - Management
   - Provider
   - Administrative (Health Home)

3. Negotiation Considerations
Types of Insurance

- Insurance Companies are licensed under Articles 42 or 43 of the Insurance Law and not bound by the same regulatory, statutory and contractual requirements imposed on MCOs (i.e., network adequacy).
Types of Insurance (Cont.)

- A Managed Care Organization ("MCO") is organized to provide and arrange for the provision of comprehensive health services to members enrolled in an MCO.

Management Contracts

- Certified pursuant to Article 44 of the Public Health Law

- Examples: HMO, PHSP, MLTC

- An MCO ensures quality care, controls costs, aligns provider incentives to avoid overutilization of services and promotes a performance-based health care delivery system
MCO Obligations

- Assumption of Risk and Maintaining Reserves
  - Transfer of full risk gives predictability and certainty and aligns incentives
- Payment of claims
- Credentialing
- Development of network
- Utilization review and quality assurance
- Case management and Disease management
- Reduce fraud, waste and abuse
- Financial management
- Information technology
- Compliance
Medicaid MCOs
Premium Rate Methodology

- Monthly premium paid to MCO for each enrollee based on an actuarial process and not a cost-based method
- Base amount is based on MCO financial information reported on Medicaid Managed Care Operating Reports (MCCOR)
- Risk adjusted pays all MCOs the same regional average premium, adjusted by each MCO’s specific relative risk score determined using the Clinical Risk for Score Model
- DOH software puts enrollees in health status groups and severity groups
- Premium rates are established for each MCO by region for the following four groups: TANF children, TANF / SN Adults, SSI, FPH
New York State Regulators

- **Department of Health**
  - Regulates MCOs

- **Department of Financial Services (formerly Dept. of Insurance)**
  - Regulates insurance programs
  - Regulates MCO non-government programs for
    - financial solvency
    - audit standards
    - prompt pay enforcement

- **Office of the Medicaid Inspector General**

- **Attorney General**
Department of Health

- Laws, Regulations and Guidelines:
  - Laws - Articles 44 and 49 of the Public Health Law
  - Regulations - Part 98 of Title 10 of the New York Code of Rules and Regulations

- Guidelines -
  - DOH Provider Contract Guidelines of MCOs and IPAs
  - DOH Management Contract Guidelines of MCOs and IPAs
  - DOH Health Home Guidelines
Medicaid and Family Health Plus Managed Care Model Contract

Types of Agreements

- Management Contracts
- Provider Contracts
- Administrative Contracts (Health Home Contracts)
Management Contract

- A management contract is an agreement between an MCO and a Management Service Organization ("MSO").
- For the delegation of management functions (defined in 10 NYCRR 98-1.11).
- Management functions are elements of an MCO governing body’s management authority.
- Some Management functions must not be delegated by an MCO to another person or entity.
- Other management functions may be delegated to another person or entity, but only pursuant to a management contract approved by DOH.
Examples of Management Functions

- Claims Payment
- Utilization Review
- Quality Assurance
Provider Contract

- A Provider Contract is an agreement related to the provision of health care services between a provider or IPA and an MCO, which is subject to NYS Department of Health (“DOH”) regulations and guidelines.

- The services rendered under a Provider Contract should reflect the scope of services of the licensed entity(ies) entering into the Provider Contract.
  - Mental Health and Substance Abuse Services
  - Home Care
  - Hospital and Physician Services
Provider Contracts

- Key Terms
- Regulatory Provisions
- Contractual Obligations Imposed on Medicaid Managed Care Organizations
- Compensation
- Regulatory Review Process
Provider Contracts
Key Terms

- The Parties
  - Need to know the legal names
  - An MCO can’t contract with any entity which proposes to provide the service of an IPA.
  - An IPA is an independent practice association (network intermediary).
Provider Contracts (Cont.)

Key Terms

- **Scope of Services**
  - What services are being contracted?
  - Payment must be tied to the services contracted.

- **COB and Payment Adjustments**
  - Need to agree upon how these activities will be handled (for example, the timeframe and notice requirements and payment implications).
Provider Contracts (Cont.)

Key Terms

- **MCO Administrative Requirements** - Providers must comply with MCO policies and procedures, but can also agree to contractual provisions, such as:
  - Timely filing of claims
  - Claim disputes
  - Credentialing

- **Insurance and Indemnification**
  - MCOs will require insurance
  - Contractual v. Common law
Provider Contracts (Cont.)

Key Terms

- Term and Termination
  - Evergreen
  - Renewal
  - For Cause v. Without Cause
  - Notice for Termination
Provider Contracts (Cont.)

Key Terms

- **Amendment**
  - Mutual agreement v. Automatic
  - Changes due to regulatory requirements

- **Assignment**
  - On notice or with consent
  - Change of control

- **Representations and Warranties**
  - Licensure
  - Medicaid Provider Status
  - Not suspended or terminated from a federal health care program
Provider Contracts (Cont.)
Regulatory Provisions

- Key Provisions of Standard Clauses

  - No balance billing
  - Continuity of Care
  - Term and Termination
Provider Contracts (Cont.)
Regulatory Provisions

- Provider / Consumer Protections
  Imposed by Law
  - Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996)
  - Chapter 551 of the Laws of 2006
  - Chapter 451 of the Laws of 2007 and
  - Chapter 237 of the Laws of 2009

The statutes address the minimum requirements, but in certain instances the parties can agree upon provisions that are more protective of the provider.
Provider Contracts (Cont.)
Contractual Obligations Imposed on Medicaid MCOs

- Network adequacy
- Quality incentive bonus
- Access requirements (Hours / Time / Distance / Cultural Competency)
- Enrollee rights
- Complaints / grievances and appeals
- Provider directory
- Carve out services
- Self-referral rules
- Fraud, waste and abuse prevention and detection
Provider Contract (Cont.)
Compensation

- Non Risk
  - Fee-For-Service
  - Unit Cost
  - Per Diem
Provider Contracts (Cont.)
Compensation

- **Risk**
  - Capitation (Regulation 164)
  - Bundled Payment
  - Global risk
  - Risk Corridor
  - Fee-for-service plus medical budget with shared risk or upside bonus

- **Risk Sharing Arrangements**
  - Align incentives, but provider must be well-suited to assume risk
  - Reserves maybe required depending on the level of risk assumed
  - Prepayment
  - Risk for services of other providers
Provider Contracts (Cont.)

Compensation

- When to Contemplate a Risk Arrangement:
  - Understand your data (information technology capabilities)
  - Manage utilization (find ways to save money)
  - Mutuality (risk and reward)
  - Control over the services in which you are assuming risk
  - Risk for own services
  - Risk for services other providers render
Provider Contracts (Cont.)
Regulatory Review Process

- DOH approval
- Changes to Provider Contracts
- Takes at least 30 to 90 days for approval
- Can’t be implemented unless approved or the time period has elapsed
Provider Contracts (Cont.)

Regulatory Review Process

- Provider Contract Statement and Certification Form (4255)
  - Specify if the contract contains an exclusivity, exclusion or most favored nation provision
  - Identify contracted services
  - Detail financial arrangement
  - Identify contracting parties

- MCO Officer or Legal Counsel must attest that the Provider Contract complies with all laws and regulations.
Administrative Contract

- Any functions (other than medical services) that an MCO is not prohibited from delegating by 10 NYCRR § 98-1.11(i), and that are not functions listed in 10 NYCRR § 98-1.11(j) requiring DOH approval of a management contract.

- An Administrative Contract includes administrative expenses provided through the contract that the MCO would otherwise have reported on the MCO’s own cost report.
Administrative Contracts

- Contracting for services that are not:
  - the provision of medical care or
  - a management function.

- Technically, not subject to DOH review and approval.

- Exceptions
  - health homes
  - consumer directed personal assistance programs personal care
  - transportation
Health Home

- **A Health Home Contract**
  - It is Not a Provider Contract
  - It is Not a Management Contract

- **What is it?**
  - It is similar to an Administrative Contract subject to limited regulatory review
General Health Home Information

- Established by 42 U.S.C. §1396w-4
- A Health Home provides coordinated care for individuals with chronic conditions.
- A Health Home is a designated provider selected by an eligible individual with chronic conditions to provide health home services.
General Health Home Information

- Health Home Services include:
  - Comprehensive care management;
  - Care coordination and health promotion;
  - Comprehensive transition care;
  - Patient and family support;
  - Referral to community and social support services;
  - Use of Health Information Technology (HIT).
Health Home Contract Between a Health Home and MCO

- Key Terms
- Regulatory Provisions
- Contractual Obligations Imposed on Medicaid MCOs
- Compensation
- Regulatory Review Process
- Downstream Contracts between Health Home and Health Home Services Providers
Key Terms

- Definitions
  - Candidates v. Participants
  - Enrollment, Activation, De-Activation, Assignment and Re-Assignment
  - Participating Provider v. Health Home Services Provider
  - Provider Network v. Health Home Service Organization
  - Other Definitions to Understand:
    - Provider Manual
    - Utilization Management
Key Terms (cont.)

- **Scope of Services:**
  - Provide outreach, contact and engagement services to Health Home Candidates
  - Obtain signed NYSDOH approved “Health Home Services Consent Form” from Health Home Candidates
  - Conduct a comprehensive assessment of each Health Home Participant, including medical, behavioral, functional and social support needs
  - Provide behavioral health expertise and leadership, as applicable, for individuals with Serious Mental Illness (SMI) and those with substance use disorders (SUD)
  - Develop an integrated care plan for physical and behavioral health disorders, as applicable.
Key Terms (cont.)

- **Scope of Services**
  - Prepare and maintain a comprehensive plan of care, including information from the providers of clinical, behavioral and social support services
  - Coordinate care by and among Health Home Services Providers and Participating Providers
  - Provide any or all Health Home Services to Participants
  - Coordinate non-health service providers and local government agencies
  - Report to MCO on activities and services in a format and within timeframes designated by MCO and/or NYSDOH
  - Provide data management to MCO in compliance with the data submission requirements of MCO and NYSDOH
Key Terms (cont.)

- Protocols
- Representations and Warranties
Key Terms (cont.)

- Monitoring, Auditing
- Reporting
  - Quality Measures
- Maintenance of Records
Key Terms (cont.)

- **Term and Termination**
  - For Cause and Without Cause
  - Notice Provisions

- **Post Termination Obligations**
Key Terms (cont.)

- Indemnification
- Non-Discrimination
- Confidentiality
Key Terms (cont.)

- Payment - Rates for Health Home Services
  - Capitation rate for Health Home Services, Outreach and Engagement
  - Bill MCO monthly
  - MCO pays within 30 days after receive money from DOH
  - Not include claims for medical services
  - MCO is not responsible for payment to downstream Health Home Services Providers
  - Re-Assignment and Termination of Participants
  - Adjustments for Overpayments
Key Terms (cont.)

- **Payment - Rates for Administrative Services**
  - Administrative Payment (6% of Capitation Rate)
  - 3% of Administrative Payment to MCO for:
    - Assignments
    - Tracking Sheets
    - Payment Responsibilities

- **Anything over and above 3% to MCO is subject to negotiation, but will be scrutinized by DOH**
Other Terms to Consider

- Verification of Eligibility
- Network Directory
- Updating Information re: Health Home Services Providers
- HIPAA
- Insurance
- Lobbying Certification
- Amendment
- Assignment
- Notice to Members
- Dispute Resolution
Regulatory Provisions

- Standard Key Terms - must be attached to and incorporated into Health Home Contract or key terms must be embedded in the body of the Health Home Contract

Medicaid Managed Care Model Contract

**MCOs:**

- Must directly provide Health Home Services or subcontract with qualified providers to provide these services to eligible Enrollees.
- The network must include a sufficient number of Health Home providers to serve all eligible Enrollees.
- Pass fee (in whole or in part) to the Health Home provider(s) commensurate with the scope of services provided.
Regulatory Review Process

- The Health Home Contract Between the Health Home and MCO is:
  - Subject to DOH approval
  - If implemented prior to approval, the parties must agree to incorporate all modifications required by DOH or must terminate the contract 60 days after notice from DOH.
  - Template Agreements v. Negotiated Health Home Agreement
  - Changes to Health Home Agreements
Regulatory Review Process

- **DOH Health Home Contract Statement and Certification Form**
  - MCO Officer or Legal Counsel must certify compliance with all laws and regulations.
  - Key provisions must be annotated and identify any modifications to the key contract provisions.
  - Identify withhold, incentive payments and sanctions.
  - Identify whether MCO will pass total Health Home payment from State to Health Home or if MCO will retain a percentage; if so, what percentage and, if MCO retains more than 3% of the Health Home payment, why.
Downstream Contracts with Health Home Services Providers

- **Things to Consider**
  - Not subject to DOH review and approval
  - Payment for actual Health Home Services
  - OMIG
  - Record Retention
  - Audit
Other Things to Know and Consider

- Leverage
- Business profile of the Parties
- Competitors of the Parties
- Strengths and opportunities
- Partnership to foster win/win
▪ QUESTIONS