The Do’s and Don’ts of Provider Contracting
DISCLAIMER: EDUCATIONAL ONLY

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Overview

• Legal Status of Community Centers
• How Legal Status Impacts Contract Negotiations
  • Medicaid Provider Enrollment
  • State Agencies
  • Managed Care Organizations
• Moving beyond FFS Contracting (Negotiating Value-based Payments)
Community Centers – What are We?
Community Centers are Governmental Entities
Texas Health & Safety Code §534.001

As governmental entities, Community Centers receive protections and benefits
Examples of Governmental Entity Protections & Benefits

<table>
<thead>
<tr>
<th>Law</th>
<th>Provides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Tort Claims Act</td>
<td>Sovereign immunity</td>
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<tr>
<td>Interlocal Cooperation Contracts</td>
<td>Ability to contract with other governmental entities without going through a competitive procurement</td>
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<tr>
<td>Self-Insurance by Governmental Units</td>
<td>Ability to self-insure</td>
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Medicaid Provider Enrollment

Problems

• Application written for private providers
• Disclosure of ownership and controlling interest
• Required Medicare enrollment for non-Medicare services
• Required application fees for exempt provider types

Work-around

• TMHP staff trained
• Re-enrollment FAQ on Texas Council Intranet
State Agency Contracts

Problems

• Non-governmental versions do not recognize governmental status
• Immunity for the State Agency only
• One-way termination
• Possible scope creep through technical guidance letters (TGLs)

Work-around

• Ask for UTCs for Local Governmental Bodies
• Negotiate changes through “Supplemental Conditions”
Managed Care Contracts

• Overview of Laws and Regulations Governing MCOs
• How to Spot a Required Clause (Medicaid & CHIP)
• Problematic Clauses
• Moving beyond FFS Contracting
Managed Care Laws & Regulations – One Pot, Many Cooks
## Managed Care Laws & Regulations

<table>
<thead>
<tr>
<th>Agency</th>
<th>Programs Administered</th>
<th>Examples of Governing Laws &amp; Regulations</th>
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<tbody>
<tr>
<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
<td>Medicare, Medicaid, Exchange, CHIP</td>
<td><strong>Social Security Act</strong> – Titles XVIII (Medicare), XIX (Medicaid and Exchange), and XXI (CHIP)</td>
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<tr>
<td></td>
<td></td>
<td><strong>Code of Federal Regulations</strong> – 42 CFR Parts 422 (Medicare Advantage), 438 (Medicaid Managed Care), and 457 (CHIP)</td>
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<tr>
<td>Texas Health &amp; Human Services Commission (HHSC)</td>
<td>Medicaid, CHIP</td>
<td><strong>Texas Gov’t Code</strong> -- Chapter 533 (Medicaid Managed Care)</td>
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<td><strong>Texas Health &amp; Safety Code</strong> – Chapter 62 (CHIP)</td>
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<tr>
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<td></td>
<td><strong>Texas Administrative Code</strong> – Title 1, Part 15, Chapters 353 (Medicaid Managed Care), and 370 (CHIP)</td>
</tr>
<tr>
<td>Texas Department of Insurance (TDI)</td>
<td>Texas HMOs, PPOs, POS, etc.</td>
<td><strong>Texas Insurance Code</strong> – Chapter 843 (HMO Act)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Texas Administrative Code</strong> – Title 28, Part 1, Chapter 11 (HMOs); 28 TAC §21.2826 (Waiver of TDI requirements for Medicaid and CHIP)</td>
</tr>
<tr>
<td>Others</td>
<td>TRICARE, ERISA-exempt, CHAMPVA</td>
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Medicaid and CHIP MCO Contracts – Mandatory Clauses

HHSC’s MCO Provider Contract Checklist

- Uniform Managed Care Manual, Chapter 8.1
- *Italicized* = MCO has to use HHSC’s language
MCO Provider Contract Checklist -- Examples

- Access to records
- Audits and investigations
- Behavioral health
- Claims payment
- Complaints and Appeals
- Confidentiality
- Copayments and deductibles for CHIP members
- Early Childhood Intervention (ECI) requirements
- Fraud and Abuse
- Laws, rules and regulations
- Liability for MCO insolvency
- Marketing restrictions
- Medical consent requirements for STAR Health members
- Mental health – Targeted Case Management/Mental Health Rehabilitation services
- Private pay forms for non-covered services
- Professional conduct
- Professional liability insurance
- Restrictions on balance billing members
- Termination
- Texas Health Steps requirements
- Third party recoveries
- TPI/NPI requirements
- Wait times for appointments
- Women, Infant and Children (WIC) coordination
MCO Provider Contract Checklist -- Highlights

- **Professional Liability Insurance** – not required for Governmental Entities
- **Claims Payment** – when payment is based on a fee schedule, the contract has to include clear directions on how to access the schedule
- **Adjudications Standards** – 30 days for most clean claims (18/21 days for pharmacy), 18% interest
- **Records, Audits, Investigations** – broad access for regulatory agencies, retention periods may be longer than other contracts
- **Outpatient Follow-up after Inpatient Psychiatric Admission** – required within 7 days of discharge, provider must call member within 24 hours after missed appointment
Problematic Clauses

• Attorneys fees
• Audits, take-backs, offsets
• Binding arbitration
• Evergreen contracts with static fee schedules
• Indemnification
• Professional Liability Insurance
• Silence as acceptance
• Responsibilities after termination
Beyond FFS – To the Moon?
Beyond FFS – the Changing Role of MCOs

**Past**
Transaction Focused
- Payment Method – FFS
- Focus on Cost Shifting and Claims Processing

**Present**
Provider Focused
- Payment – FFS, some VBP
- Focus on Reducing Unnecessary Supply

**Future**
Consumer Focused
- Payment – VPB
- Focus on Preventing Demand
Preparing for Negotiations – Identify Your Strengths

• How can my Center help the MCO meet its contract requirements?
• How can my Center add value while helping reduce costs?
<table>
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<tr>
<th>STP Participation</th>
<th>Access to Care</th>
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<td>Care Coordination &amp; Service Management</td>
<td>Quality/At-risk</td>
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Requirements
Are you a SIGNIFICANT TRADITIONAL PROVIDER (STP)?

MCOs are required to offer network provider agreements to Medicaid STPs.

• LMHAs are STPs.
• STP requirements are not service-limited.
• Restricts MCOs from terminating STP contracts.
• STP lists are available on HHSC’s website for each managed care procurement.
Can you help the MCO meet its ACCESS REQUIREMENTS?

Access Standards

Mileage Standards
- PCPs and Urban BH Providers – 30 miles
- Specialists – 75 miles

Wait Times for Appointments
- Emergency services – upon presentation
- Urgent Care – 24 hours
- Initial outpatient BH – within 14 days
- BH visit after psychiatric admission – 7 days after discharge

Out-of-Network Utilization – 20% for outpatient services

Before Negotiations

Do a market analysis. Fewer providers = greater value.

Check with HHSC – is the MCO meeting metrics?

Other factors -- are there external factors influencing the MCO?
Can you help the MCO with CARE COORDINATION or SERVICE MANAGEMENT?

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<th>Requirement</th>
<th>Before Negotiations</th>
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<tr>
<td><strong>MCO Service Coordination</strong></td>
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<tr>
<td>• STAR+PLUS and STAR Kids</td>
<td>• Can you help with the MCO touch requirements?</td>
</tr>
<tr>
<td>• Members are placed into different “levels” of Service Coordination based on needs</td>
<td>• Are you qualified to serve on a Service Coordination Team?</td>
</tr>
<tr>
<td>• MCOs must meet in-person and telephonic “touch” requirements.</td>
<td><strong>Health Home</strong></td>
</tr>
<tr>
<td><strong>Health Home</strong></td>
<td>• Meet qualifications?</td>
</tr>
<tr>
<td>• Team-based approach to patient-centered care</td>
<td>• Integrated services or written arrangements for referrals?</td>
</tr>
<tr>
<td></td>
<td>• How can you help ensure coordinated care?</td>
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</table>
Can you help the MCO with QUALITY and AT-RISK METRICS?

**Requirement**

**Pay for Quality (P4Q)**
- 4% of MCO’s payment placed at risk
- Currently focused on
  - PPEs (all programs)
  - Well-child visits (STAR)
  - Antidepressant medication management (STAR+PLUS)

**Performance Improvement Projects (PIPS)**
- 2 required per program
- Topics include:
  - Antidepressant medication management
  - Adherence to antipsychotic medications
  - Follow-up after BH hospitalization
  - Improving care transitions and care coordination to reduce BH-related admissions and readmissions

**Before Negotiations**

**Can you offer better quality and cost savings?**
- Better management of BH or SUD clients
- Identification of undiagnosed BH or SUDs
- Case-by-case, in lieu of, or value-added services (mobile crisis outreach, crisis respite or residential services, wellness programs)
- Medication management and adherence
- Data to support cost savings?
Preparing for Negotiations – the Final Steps!

• Know your costs and other contracts.
• Are you ready to participate in Value-based Payments?
  • Do you have the capacity to incur some downside financial risk?
    • Capitated payments are highest risk
    • Bundled payments and case rates for specific diagnoses or conditions
    • Shared savings/losses based on total costs of care
  • If not, then consider FFS payments with bonuses tied to metrics.
• How will you communicate your value?
  • Marketing materials that communicate the full array of services
  • Onsite tours of your facilities and services
  • Data on metrics, quality outcomes, or potential savings
Negotiating the Contract

• Review
• Prioritize
• Focus on Common Goals
Negotiating the Contract -- Review

• Do you understand all the provisions and plan requirements?
• Are there provisions that disadvantage your Center from a financial, clinical, operational or legal perspective?
• Are each party’s responsibilities clearly stated?
• Are all attachments included?
• Look at the MCO’s Provider Manual and other policies and procedures that are referenced in the contract.
• Review references to laws, rules, and regulations.
• Does the contract reflect sound business judgment?
Negotiating the Contract -- Prioritize

- Make a list of issues you identified during the contract review process
  - Red = unacceptable risks, must change
  - Yellow = potential risk, need clarification or change to move forward
  - Green = low risk, good to have
"Don't let it throw you - it's just a negotiating tactic."
Negotiating the Contract -- Focus on Common Goals

**Do’s**

- Educate the other party about your concerns
- Ask questions and listen to their concerns
- Voice options for mutual gain
- Include objective and clearly articulated standards and methodologies
- Emphasize the importance of maintaining ongoing relationships

**Don’ts**

- Take extreme positions, assuming the other party will have room to bargain
- Win the battle to lose the war
- Saturate the document with red ink
Closing Thoughts

“In business as in life, you don’t get what you deserve you get what you negotiate”

- Chester L. Karrass -
Panel Discussion

Armida Valles, Sr. Director of Managed Care and Government Programs, Western Behavioral Network

John K. Connors MEd, LPC, Managed Care Director, Tejas Health Management
Continuing Legal Education

This session qualifies for 1.5 hours of CLE credit.

Course Title: 31st Annual Conference
Course Number: 901353698
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