Tool 2: Components of Successful Contracting and Management of Contracts with Payers

The Trusted Voice for Aging

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Center for Managed Care Solutions & Innovations

Tool Summary

- Key Considerations Prior to Contracting with Health Plan or Health System
- Basic Sections of the Contract
  - Master agreement
  - Payment addendum
  - Product listing addendum
  - Service provider's list of organizations/services
  - Provider participation addendum (specific language required by CMS or State as part of Medicare or Medicaid plan)
- Identify Specific Reimbursement Models for Contract with Health plans
- Include Template/Sample of Contracts as Resource

Key Considerations Prior to Contracting with Health Plans

- What product(s) does the health plan offer?
  - Medicare Advantage
  - Medicare Advantage/Special Needs Plan (SNP)
    - SNP – dual eligibles
    - SNP – institutional
    - SNP – chronic condition (e.g., end-stage renal disease)
  - Medicaid managed care
  - Commercial products
- Which governmental entity controls the agreement with the health plan?
- Obtain any documents that explain program requirements for:
  - CMS – Medicare Advantage
  - CMS/State – Medicare Advantage/SNP Plans for Dual Eligibles
  - CMS/State – Medicaid Managed Care/Waivers to State Medicaid Plan

Basic Sections of the Master Contract

- Master Contract (body of contract) ***See Exhibit 2A***:
  - Includes standard definitions, enrollment and quality assurance language required by CMS and/or state to operate program
  - Includes other sections/provisions that health plan believes are essential in operating plan
  - Any changes, if necessary, are usually handled through addendums or amendments to master contract
  - Term of master contract is usually multi-year with automatic extensions
  - Payment addendum duration is usually 1-2 years with specific reimbursement/rate schedules for services provided
  - Provider manuals referenced in master contract are critical to managing services; available online from the plan

Key Sections of Master Contract Definitions

- **Plans, Payers and/or Clients:** Ensure that these terms are not defined overly broadly to avoid extending discounted rates to services furnished to an unintended scope of individuals.
- **Covered Services:** Your principal obligation under the agreement is to furnish "covered services" to the plan's members. Ensure this term is carefully defined in light of the full scope of services you intend to provide and for which you expect to be paid. Where possible, consider listing and defining each service by developing a separate addendum.
- **Medical Necessity:** Ensure that the definition of "medical necessity" does not give the plan the sole authority to determine what is medically necessary. Instead, the definition should rely upon the clinical judgment of the provider and/or community standards.
- **Standard of Care:** Avoid provisions that impose a duty on you to furnish the "highest" or "best" quality of care. These types of provisions can enable plans to prevail more easily in a breach of contract action, and they might provide an easier path in medical malpractice claims.

Key Sections of Master Contract Definitions

- **Delivery of Services:** Ensure that you not only know the scope of covered services under the contract but also understand and accept any terms and conditions regarding the delivery of those services (e.g., prior authorization requirements, qualifications of the caregiver, etc.)
- **Records Requirements:**
  - Does the contract impose records maintenance and/or retention obligations that differ from your standard practices?
  - Consider negotiating a general provision stating that Provider must retain patient records for the period prescribed by applicable state and federal law

Key Sections of Master Contract Definitions

- **Policies and Procedures** –
  - Watch for provisions that are incorporated by reference, such as the plan's policies, guidelines or other standards. Obtain copies of any such documents before executing the contract.
  - Ensure that the contract does not permit the plan to change those standards and enforce them under the contract without advance notice to you. You should have the right to terminate a contract if you disagree with changes to the contract's policies, guidelines or its other standards.
  - Ensure that you are aware whether the contract of the standards govern in the event of a conflict between the two.

Key Sections of Master Contract Definitions

- **Audits:**
  - Carefully review and understand the plan's rights to conduct audits under the contract and who pays for the audit.
  - Does the contract allow the plan to use statistical methods to project alleged over-payments? If so, how should provider respond?
  - What is the look-back period for audits?

Key Sections of Master Contract Definitions

- **Utilization Management:**
  - Understand who at the plan performs utilization management (e.g., qualified clinicians) and how such utilization management is carried out
  - Understand how plan member eligibility is verified and what is required of the provider in this process
  - Understand how much time the plan has to respond to prior authorization requests and whether it is reasonable
  - Know your appeal rights in the event you disagree with a plan's decision on prior authorization

Key Sections of Master Contract
Claims Payment

- **Time Period and Process for Submitting Claims:** Compare to your standard practices and consider negotiating "special circumstances" provisions to permit you additional time to submit claims in certain situations (e.g., question of workers comp coverage for portion of claim).
- **Who is responsible for paying and what is the timeframe?** Negotiate for payment within 90 days for a clean claim.
- **Nonpayment:** In addition to the right to terminate, the provider should reserve the right to suspend services and impose penalty fees in the event of non-payment by the payer (or other entity responsible for payment).
- **Retroactive Denial of Claims:** Negotiate provisions that prohibit the plan from retroactively denying claims that were positively adjudicated absent fault or fraud of the Provider. Consider also negotiating cut-offs for any look-back time periods.

Key Sections of Master Contract Term/Termination

- **Contract Duration:** Ensure there is a clear statement of contract duration.
- **"Without Cause" Termination:** Carefully review the termination provisions of the proposed contract. Consider negotiating a mutual right to terminate without cause with reasonable advance notice periods (e.g., 120 days) and clear requirements for submission of and payment of prior claims post-termination.
- **For-Cause Termination:** Consider including a cure period for any alleged "for-cause" termination reason. For-cause termination can have collateral impact for providers in certain situations, and therefore, providers should ensure that the health plan's standards are clear.

Basic Sections of Payment Addendum

- Is a separate addendum negotiated annually or longer that specifies reimbursement rates for services provided (***see Exhibit 2B***)?
- Identifies any excluded services that are not part of the reimbursement rate
- May include special outliers that are negotiated for high costs: items such as drugs, wound vac machines, bariatric equipment
- Can include a separate section on pay for performance plan (P4P); this P4P plan may also be handled as a separate addendum to contract (***See Exhibit 2E***)

Basic Sections of Product Addendum

- Many health plans offer multiple products (e.g., Medicare Advantage, Dual Eligible SNP, Medicaid Managed Care) to the customer and require providers to offer their services to all enrollees of the health plan
- Addendum should include either:
  - A separate statement that all products are covered and a list of those products . ***See Exhibit 2C***
  - A listing of the specific product names covered under the contract by product type, for example:
    - Blues Gold: insurance plan for Medicare Advantage members
    - Blues Basic: insurance plan for all Medicaid members
    - Blues Premier: insurance plan for all commercial plan enrollees

Basic Sections of Provider Participation Addendum

- Listing includes name, address and unique provider ID number for each provider covered under the contract (example): ***See Exhibit 2D***

Type of Service	Name and address	Provider ID
Skilled Nursing Home-PAC	Boyton Nursing Home 1841 Huron Avenue Roseville, MN	National Provider ID (NPI) and/or tax ID
Nursing Home- LTSS	Boyton Nursing Home 1841 Huron Avenue Roseville, MN	Medicaid Number
Home Health Care	Boyton Home Health Care Agency 2540 Snelling Avenue St. Paul, MN	National Provider ID (NPI) and/or tax ID
Medicaid LTSS	Boyton Adult Day Center 4200 Fairview Avenue St. Paul, MN	Medicaid Number

REIMBURSEMENT AND PAYMENT MODELS

General Description of Reimbursement and Payment Models

- **Rate reimbursement methodology used by health plans**
  - **Basic rate:**
    - Use CMS existing rate methodology (e.g., RUGS or Patient Driven Payment Model (PDPM) for SNFs) or rate table used by CMS or state for other specific services
    - Percentage of existing rate methodology or rate table used by CMS or state for specific service
    - Health plan develops its own service definitions and rate schedule based on health plans' data
    - **Contract Alert**: Regardless of rate methodology, providers are encouraged to try to avoid contract language that states the plan will either "pay the rate or charges" or "the lessor thereof" in that the organization has no mechanism to cover costs that exceed the approved contracted rate. If the "lessor there of" is accepted, the facility should have justifiable charges/markup on items such as contracted pharmacy and rehabilitation services and coverage of indirect administrative costs for all services, when appropriate. This methodology is commonly used in hospitals and usually results in appropriate charges being higher than a negotiated rate.
  - **Negotiate exclusions and outliers to rates for high-cost items**

General Description of Reimbursement and Payment Models

- **Types of Pay-for-Performance (P4P) Incentive Plans:**
  - Provider is eligible for defined P4P dollar amount based on meeting defined quality or other performance metrics
  - Provider is eligible for a percentage of medical pool expenses (individuals whose medical costs are combined to calculate premiums) for select services provided based on meeting defined quality metrics

- **Shared Savings Models:**
  - Provider and health plan/health system share percentage of savings generated for all medical expenses provided to health plan members served by its providers and facilities
  - Provider and health plan/health system share percentage of savings generated for specific episode of care provided to each plan member (e.g., total joint replacement)

Examples of Reimbursement Models used by Health Plans for Select Services

Type of Service	Medicare Advantage Options	Medicaid
Post-Acute Care in a Skilled Nursing Facility (SNF) and/or Transitional Care Unit (TCU)	1. Use a percentage of RUG or PDPM rates 2. Set up 3-5 clustered rate levels based on RUGS or PDPM 3. Flat rate	1. Use a percentage of RUG or PDPM rate 2. Bill state's Medicaid-approved custodial rate with separate billing for therapies and drugs
Nursing Home Custodial Rate		1. State sets rate 2. State sets rate for a period of time (2 yrs.) 3. Health plan sets flat rate based on % above State rate 4. Health plan sets rate based on negotiation with provider

Example of Clustered Rate Cell Reimbursement Model for PAC Services in Nursing Home

- Key Points in Clustered Rate Cell Model:
  - Need at least 4-5 clustered rate cells to ensure adequate reimbursement for range of services provided
  - Need facility data analysis to determine adequacy of rate proposed by health plan

Rev Code	Per Diem Rate	Description
191	$317	Level 1-Skilled/Behavioral Care/No Rehab: Enrollees assigned to this category require skilled nursing services. Rehabilitative therapy services are not medically necessary and are not included in this category. No rehab. (Although not Medicare client, still complete a "mini MDS" to estimate RUGS category rating as if Medicare client.)
192	$434	Level 2-Complex Medical: Enrollees assigned to this category require complex nursing services such as IV feeding or medication, suctioning, tracheostomy care or comorbidies. Rehabilitative therapy services are not medically necessary and are not included in this category.
193	$504	Level 3-Moderate/Low Rehab: Enrollees assigned to this category require skilled nursing services and have had rehabilitative therapy services, up to 500 minutes of therapy per week, on at least 5 days, which may be any combination of physical therapy, occupational therapy and speech.
194	$544	Level 4-High Rehab: Enrollees assigned to this category require skilled nursing services and have had rehabilitative therapy services, between 500 minutes and 720 minutes of therapy per week, on at least 5 days, which may include any combination of physical therapy, occupational therapy or speech.
199	$675	Level 5-Very High Rehab/Complex: Enrollees assigned to this category require skilled nursing services. Enrollees assigned to this category require rehabilitative therapy services of 720 minutes or more per week, on at least 5 days, which may include any combination of physical therapy, occupational therapy or speech therapy.

Exclusions /Outliers to Basic Reimbursement Rate

- **Rationale for Exclusions/Outliers:**
  - Excluded items are usually high-cost items that are difficult to manage or fund within a set per diem rate
  - Encourages an organization to take more medically complex patients from hospitals
  - Need to include language on how items are reimbursed or billed (e.g., cost)

Examples of Exclusions/Outliers to Basic Reimbursement Rate

- **Examples of Excluded Items:**
  - Medical transportation
  - Total parenteral nutrition (TPN)
  - Remodulin therapy
  - Specialized durable medical equipment, including bariatric durable medical equipment, modified/customized to meet enrollee's needs secondary to specific diagnosis
    - For such products and/or services, participant shall work with and defer to health plan or the enrollee's primary care physician to determine coverage per the enrollee's certificate of coverage and medical necessity, and to arrange for such products and/or services as appropriate
  - Medically necessary private room, differential of $35 per day
  - Vacuum-assisted closure (VAC) devices
  - Custom orthotics and prosthetics, including therapy beds (Clinitron, Kin Air, etc., including powered-type products such as Micro-Air and Pneucair)
  - Mental health and/or substance abuse services
  - Motorized wheel chairs or other motorized vehicles

Examples of Outlier Reimbursement for High-Cost Drugs

- **Rationale for Exclusions/Outliers:**
  - Excluded items are usually high-cost items that are difficult to manage or fund within a set per diem rate
  - Encourage provider to take more medically complex patients from hospitals
- **Examples of Reimbursement Models for Drugs:**
  - Exclude a specific list of drugs and have pharmacy bill health plan separately (more common in commercial plans) or
  - Reimburse when drugs exceed a predetermined monthly threshold for a patient
  - Reimburse separately for list of high-cost drugs separately negotiated
    - Provider should obtain a list of high-cost drugs from its institutional pharmacy
      - E.g., Abilify, Anzemet, Aranesp, Cubicin, Copaxone, Epogen, Eraxix, Humira, Leukine, Lovenox, Kytril, Lupron, Maxaquin, Neulasta, Neupogen, Procrit , Provigil, Vancocin, Vancomycin, Zoladex, Zofran, Zosyn
    - Review CMS list of specialty drugs – Levels 4 and 5
    - Provider bills separately for items

Overview of Types of Performance Incentive Plans

Pay for Performance Incentive Pools – Health Plans/ Health Systems

Sharing/Risk Plans

Performance Plan Based on Incentive Pool Approach Model 1

- Set up pool based on agreed upon methodology and defined performance/outcome criteria:
  - **Pool Size**
    - Percentage of SNF – Medicare Part A TCU expenses for any member
      (Example: 1-5% of all Medicare Part A for members within a health plan or under ACO); or
    - Based on an established amount per member per month and membership within health plan; or
    - Based on number of patients cared for under bundled payment model and estimated savings based on length of stay reduction
  - **Quality Measures:**
    - Based on 4-5 outcomes commonly tied to reduction of readmissions, improved patient outcomes or criteria tied to assisting health plan to meet CMS quality metrics for health plan

Performance Incentive Models
Model 1 Example

- **Pool based on percentage of SNF-A expenses spent by health plan at nursing home or flat dollar amount:**
  - 5% of $10,000,000 = Performance pool total $500,000
  - Flat Dollar amount: $800,000
- **Criteria: tied to CMS and state criteria**
  - 30% of incentive payment tied to percentage reduction in readmissions/transfers to hospitals
  - 10% flu shots – offered to 90% of nursing home residents
  - 10% – limit falls with injury to no more than a certain percentage of population
  - 30% – completion of POLST forms/family care conferences
  - 20% – increase in palliative care

Example Contract Language for Pay for Performance Plan

Exhibit 2E

Measure	Criteria for Payment	Reporting Method	Weight
Reduce TCU readmissions	Reduce TCU readmissions by 5% over base year.	Care center or SNF to report	30%
Reduction of LTC inpatient days per 1000	Inpatient days/1000 for 2018 dates of service for health plan members who are in an institutional rate and reside in participating nursing communities must decrease by five percent (5%) or more, as compared to base year inpatient days/1000.	Health plan calculation based on claims data	20%
Provision of flu vaccine	Ninety-five percent (95%) or more of all residents in nursing facilities in 2018 must be offered a flu vaccine in that year, in accordance with CMS regulations.	Provider to report to health plan	10%
Falls prevention program	Maintain a ratio of falls with injury (as defined) of less than 1% per year. The ratio will be expressed as reportable falls divided by the total resident days.	Provider to report to health plan	15%
POLST Usage	At least 70% of LTC members will utilize POLST form.	Provider to report to health plan	25%

Key Lessons Learned: Model 1 Incentive Pool

- **What is base year for performance outcomes:**
  - Percentage improvement over what year; will always have readmissions
  - Know base year so percentage improvement is realistic
- **Define outcomes carefully:**
  - Does readmissions include all or just “unplanned”?
  - Falls: only those with injury as defined by MDS?
  - Which populations are included in which measures?
- Stagger percentage improvement over multiple years if it is a stretch goal/new outcomes
- Know that facility has the ability to influence and improve outcome

Key Lessons Learned: Model 1 Incentive Pool

- Who collects data/reporting requirements?
  - Do you report progress to the health plan during the year?
- Try for multi-year plan – build toward improvement/partnership
- Define payment schedule for receipt of funds
  - Settlement is following year-after the close of the 'books"
- How do you pay out pool for multiple participating communities?
  - Based on aggregate network performance or
  - Individual community performance

Gain Sharing Type of Plans/Shared Savings Plans Model 2

- Best utilized when an entity is capitated or responsible for total cost of care (TCOC) for select population or membership (e.g., health plan, bundled payment, or ACO)
  - Options for calculating membership/enrollment
    - Based on per member per month (PMPM) and membership within health plan or ACO or
    - Based on number of patients cared for under bundled payment model and estimated savings based on length of stay reduction
- Combine all revenues generated for membership
- Include expenses associated with product/program
- Negotiate and share a percentage gains/risk at settlement time

Example of Gain Sharing
Percent of Medical Pool Model in LTC Nursing Home

See Exhibit 2F

Steps		Annual Statement	Institutional
Enrollment	Health plan member months (200 members) (institutional)		$2,400
			PMPM
Capitated revenue	Total revenue	$5,040,000.00	$2,100
Subtract admin costs	Health plan admin expense	$544,320.00	-$204
Total revenue available	Net medical pool revenue	$4,495,680.00	$1,896
All expenses	Total capitated expenses	$3,146,976.00	$1,311
	Net gain	$1,348,704.00	$562
	Less NP/care system mgmt.	$720,000.00	$300
Percent shared	Net income/shared savings pool	628,704.00	$261.96
	Care system 75%	471,528.00	$196.47
	Nursing home 25%	157,176.00	$65.49

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Key Factors for Shared Savings Plans Contract

- Health plans reward/gain but want provider to include risk
- Define membership/population of who is in the “pool”:
    - Institutional members only (custodial)
    - Any resident/patient cared for in TCU and long-term care
    - Bundled payment (by episode)
- Define if any expenses are excluded (e.g., drugs; claims over certain dollar amount)
- Discuss timing of settlement (usually 9 months after end of calendar year); ask for quarterly “installments” based on projected gain if savings are anticipated to be achieved.

Key Factors in Successful Implementation of Shared Savings/Risk

- Need to have base enrollment for institutional LTC program:
  - Need at least 150 LTC members/1,800 member months
  - Constant turnover/enrollment due to frailty/death of residents
  - Involves education of clinical/social services staff on values of care system/health plan
- For shared savings/risk model, need increased referrals/admissions for episodes covered so that you have base to manage both the upside/downside risk
- Need close relationship with nurse practitioner/physician and possible other service entities (e.g., home health)
- Need to monitor on an ongoing basis those metrics that impact costs (e.g., length of stay, readmissions)

Key Factors in Successful Administration of Health Plan Contracts by Provider

- Takes an interdepartmental team to manage contracts:
  - **Admissions:** Understand what health plan coverage patient has and whether you can manage acuity within contracted reimbursement; tracking of admissions by hospital referral source
  - **Clinical Care:**
    - Proactive management of patient's care to obtain necessary prior authorization to meet health plan's requirements
    - Development of new clinical protocols/pathways to meet increasing acuity needs of patients
    - Strong communication/relationships with practicing physician/NP teams
  - **Social Services:** Proactive care transition/discharge planning
  - **Therapies:** Management of therapy minutes within contract terms
  - **Billing:** Timely submission of claims under each health plan

Key Factors in Successful Administration of Health Plan Contracts by Provider

- Takes an interdepartmental team to manage contracts (continued):
  - **Administration:**
    - Make sure team is knowledgeable about contract terms and has access to contracts in case; suggest posting on secure central facility website or in the cloud
    - Summarize all contract reimbursement terms into single contract grid ***(Exhibit 2G)***
    - Create a fact sheet for each contract that provides more detail on rate reimbursement items and specifies who to contact if questions ***(Exhibit 2H)***
    - Need to collect financial and key clinical data to improve outcomes
    - Proactive ongoing leadership meeting with interdisciplinary team in understanding financial and clinical performance under each health plan contract
    - Proactive relationship with health plans to best position the community for reimbursement discussions and opportunities for pay for performance

Summary of Key Points in Contracting and Management of Health Plans

- **Contract Negotiations:**
  - Determine who is the main provider contact person at each health plan and establish relationship with person
  - Track financial data related to health plan rates so you can better position rate discussions with health plan
  - Monitor high-cost items and request consideration of outliers
- **Contract Language, Master Contract:**
  - Review key sections of contract and if there are concerns, propose changes to be placed in addendum to master contract
- **Preferred Provider, Health Plan:**
  - Share key clinical performance data with health plan to position as preferred provider
  - Determine whether there is opportunity for pay-for-performance or shared savings based on number of health plan enrollees served by your organization and your performance outcomes
- **Contract Management and Administration:**
  - Successful implementation of the contract requires engagement of interdepartmental team
  - Create a contract grid/fact sheet summarizing key aspects of each contract and maintain in central online file so that staff have access to them if questions

Tool 2 Exhibits

All exhibits available at: www.leadingage.org/ManagedCareSolutions or you can click on the exhibit number to go to the content.

- Exhibit 2A: Sample Master Contract with Health Plan
- Addendums To Master contract
  - Exhibit 2B: Payment Addendum
  - Exhibit 2C: Product Listing
  - Exhibit 2D: List of Providers
- Exhibit 2E: Contract for Pay for Performance Terms and Conditions
- Exhibit 2F: Contract for Shared Savings Plan Example
- Exhibit 2G: Sample Outline of Contract Grid for Administrative Team
- Exhibit 2H: Fact Sheet Example for Contract

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