Managed Care Contracting:
Basics and Beyond

Leading Age NY Financial Managers Conference

Presented By:
Steven Herbst
Director of Managed Care

Wednesday, September 17, 2014

Agenda

- Market Update
- Who are the Managed Care Plans
- Contracting Strategy
- Contract Basics
  - Terms & Conditions
  - Rate Components
- Pricing Models and Case Studies
What’s Going on in the Market Today?

- Is the nursing home long term care transition finally here?
- Planning for FIDA
- Negotiating managed care contracts
- Planning for the future

Proliferation of MLTCPs

NYC Area MLT Growth

- 25 active MLTC plans 115,000 covered lives
- 13 active MLTC plans 50,000 covered lives

August 2011 August 2012 August 2013 August 2014
**Proposed Timeline of Changes**

**SNF Transition to MLTC & Medicaid Managed Care**
- Downstate - October 2014, Pending CMS Approval
- Upstate - Potentially February/March 2015

**FIDA:**

<table>
<thead>
<tr>
<th></th>
<th>Voluntary Enrollment</th>
<th>Mandatory Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>NYC &amp; Nassau Counties</td>
<td>January 2015</td>
<td>March/April 2015</td>
</tr>
<tr>
<td>Suffolk &amp; Westchester Counties</td>
<td>April 2015</td>
<td>June/July 2015</td>
</tr>
</tbody>
</table>

**Managed Care Transition Implications**

All new custodial lives will require enrollment in managed care:
- Dual-eligible individuals will need to enroll in MLTC
- Medicaid only individuals will likely remain enrolled in their Medicaid Managed Care plan

Downstate Only:

**FIDA:**
- All residents (excluding iSNP) will receive a FIDA enrollment letter
- Passive enrollment approach means that if your residents take no action they will be enrolled into a FIDA
- Residents can always opt-out of FIDA and revert to FFS Medicare
### What Was

For your long stay residents, the payers for their services were either:

<table>
<thead>
<tr>
<th>Sub-Acute Services Payer</th>
<th>Long-Term Services Payer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare FFS</td>
<td>Medicaid FFS</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>MLTC</td>
</tr>
<tr>
<td>Medicare Advantage iSNP</td>
<td></td>
</tr>
<tr>
<td>Medicaid Managed Care</td>
<td></td>
</tr>
</tbody>
</table>

### The New Normal

All NEW long-stay residents:

<table>
<thead>
<tr>
<th>Sub-Acute Services Payer</th>
<th>Long-Term Services Payer</th>
</tr>
</thead>
<tbody>
<tr>
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<td>MLTC</td>
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<td></td>
</tr>
<tr>
<td>Medicare Advantage iSNP</td>
<td></td>
</tr>
<tr>
<td>Medicaid Managed Care</td>
<td></td>
</tr>
<tr>
<td><em>FIDA</em></td>
<td></td>
</tr>
<tr>
<td><em>FIDA</em></td>
<td></td>
</tr>
<tr>
<td><em>Medicaid Managed Care</em></td>
<td><em>No More Medicaid FFS</em></td>
</tr>
</tbody>
</table>
**Agenda**

Market Update

Who are the Managed Care Plans

Contracting Strategy

Contract Basics
  - Terms & Conditions
  - Rate Components

Pricing Models and Case Studies

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**What Kinds Of Plans**

**Medicaid Only**
- Medicaid Managed Long Term Care (MLTC)
- Medicaid Managed Care
- Medicaid HIV Special Needs Plan

**Medicare Only and Duals**
- Medicaid Managed Long Term Care (MLTC)
- Medicare Advantage
  - Dual Special Needs Plan
  - Institutional Special Needs Plan
- Medicaid Advantage Plus
- Fully Integrated Duals Advantage (FIDA)
Services Plans Will Pay For

<table>
<thead>
<tr>
<th>PROVIDER SERVICES AUTHORIZED BY MANAGED CARE PLAN TYPE</th>
<th>Medicare Advantage</th>
<th>MLTC</th>
<th>Medicaid Managed Care</th>
<th>Medicaid Advantage Plus</th>
<th>FIDA</th>
<th>HIV SNP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-Acute SNF (Medicaid Only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Custodial SNF (As of 10/1/14)</td>
<td></td>
<td></td>
<td>(As of 10/1/14)</td>
<td>(Limited)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Adult Day Care (Limited)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Adult Day Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHHA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LHCSA (Limited)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

MLTC Plans

<table>
<thead>
<tr>
<th>METRO NYC MLTC ENROLLMENT - July 2014</th>
<th>UPSTATE MLTC ENROLLMENT - July 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>PLAN NAME</td>
<td>MEMBERS Share</td>
</tr>
<tr>
<td>AETNA BETTER HEALTH</td>
<td>2,639 2%</td>
</tr>
<tr>
<td>AGEWELL NEW YORK</td>
<td>3,365 3%</td>
</tr>
<tr>
<td>ALPHACARE</td>
<td>660 1%</td>
</tr>
<tr>
<td>AMERIGROUP</td>
<td>2,828 2%</td>
</tr>
<tr>
<td>ARCHCARE COMMUNITY LIFE</td>
<td>1,854 2%</td>
</tr>
<tr>
<td>CHI SELECTION</td>
<td>8,696 8%</td>
</tr>
<tr>
<td>CENTER PLAN FOR HEALTHY LIVING</td>
<td>1,848 2%</td>
</tr>
<tr>
<td>ELDERPLAN</td>
<td>10,073 9%</td>
</tr>
<tr>
<td>ELDERSEVE</td>
<td>10,400 9%</td>
</tr>
<tr>
<td>EXTENDED MLTC</td>
<td>287 0%</td>
</tr>
<tr>
<td>FIDELIS CARE AT HOME</td>
<td>7,069 6%</td>
</tr>
<tr>
<td>GUILD NET</td>
<td>14,464 13%</td>
</tr>
<tr>
<td>HPM CHOOSE</td>
<td>2,246 2%</td>
</tr>
<tr>
<td>HPM OF THE NEW YORK</td>
<td>7,229 7%</td>
</tr>
<tr>
<td>INDEPENDENCE CARE SYSTEMS</td>
<td>6,001 4%</td>
</tr>
<tr>
<td>INTEGRA</td>
<td>1,476 1%</td>
</tr>
<tr>
<td>METROPLUS</td>
<td>663 1%</td>
</tr>
<tr>
<td>MONTETORE HMO</td>
<td>381 0%</td>
</tr>
<tr>
<td>NORTH SHORE JUV HEALTH PLAN</td>
<td>818 1%</td>
</tr>
<tr>
<td>SENIOR HEALTH PARTNERS INC</td>
<td>11,760 10%</td>
</tr>
<tr>
<td>SENIOR WOOLE HEALTH</td>
<td>1,906 1%</td>
</tr>
<tr>
<td>UNITED HEALTHCARE</td>
<td>795 1%</td>
</tr>
<tr>
<td>VILLAGE CARE</td>
<td>3,043 3%</td>
</tr>
<tr>
<td>WISE CHOOSE</td>
<td>16,904 15%</td>
</tr>
<tr>
<td>WELLCARE</td>
<td>5,966 5%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>115,256 100%</td>
</tr>
</tbody>
</table>
NYC Medicaid & HIV SNP Plans

**METRO NYC MMC ENROLLMENT - July 2014**

<table>
<thead>
<tr>
<th>PLAN NAME</th>
<th>MEMBERS</th>
<th>SHARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affinity Health Plan</td>
<td>190,340</td>
<td>8%</td>
</tr>
<tr>
<td>Amerigroup</td>
<td>325,561</td>
<td>13%</td>
</tr>
<tr>
<td>HealthFirst-Metropolitan</td>
<td>871,522</td>
<td>27%</td>
</tr>
<tr>
<td>HIP of Greater New York</td>
<td>183,877</td>
<td>7%</td>
</tr>
<tr>
<td>Hudson Health Plan</td>
<td>52,227</td>
<td>2%</td>
</tr>
<tr>
<td>MetroPlus Health Plan</td>
<td>335,129</td>
<td>14%</td>
</tr>
<tr>
<td>Fidelis</td>
<td>371,523</td>
<td>15%</td>
</tr>
<tr>
<td>United Healthcare Plan of NY</td>
<td>265,770</td>
<td>11%</td>
</tr>
<tr>
<td>Wellcare of New York</td>
<td>56,148</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,452,095</strong></td>
<td></td>
</tr>
</tbody>
</table>

**NYC MMC HIV SNP ENROLLMENT - July 2014**

<table>
<thead>
<tr>
<th>PLAN NAME</th>
<th>MEMBERS</th>
<th>SHARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amida Care SN</td>
<td>6,051</td>
<td>38%</td>
</tr>
<tr>
<td>MetroPlus Health Plan SN</td>
<td>5,256</td>
<td>33%</td>
</tr>
<tr>
<td>VNS Choice SN</td>
<td>4,879</td>
<td>29%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>15,986</strong></td>
<td></td>
</tr>
</tbody>
</table>

Preliminary FIDA Applicants

- Aetna Better Health of New York
- AgeWell New York
- AlphaCare of New York
- Amerigroup New York
- ArchCare
- CenterLight Healthcare
- Centers Plan for Healthy Living
- Elderplan
- ElderServe Health
- Fidelis
- Fidelis
- GuildNet
- HealthFirst
- HIP/Emblem
- Independence Care System
- Integra MLTC
- MetroPlus Health Plan
- Montefiore
- North Shore-Long Island Jewish
- Senior Whole Health of New York
- Village Care of New York
- VNSNY CHOICE
- WellCare of New York

*Partners Health Plan is the only OPWDD/FIDA applicant*
Agenda

- Market Update
- Who are the Managed Care Plans
- Contracting Strategy
  - Contract Basics
    - Terms & Conditions
    - Rate Components
- Pricing Models and Case Studies

Develop Your Managed Care Strategy

1. What’s Your Value Proposition?
2. Review Your Current Managed Care Contracts
3. Identify Who Do You Want To Partner With
4. How Many Contracts Do You Want To Sign?
5. Why Are You A Good Partner For A Managed Care Plan?
**Contracting Strategy**

- Develop Payment Terms
- Specify Key Terms and Provisions
- Develop Acceptable Payment Options
- Negotiate Contracts
- Improve Quality Outcomes

**Your Managed Care Contracting Strategy**

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**Long-Stay SNF Services Contracting**

- Plans are required to contract with a minimum of 2–8 SNFs depending on the county
- Plans must enter into payment arrangements with any SNF if a resident enrolls in that plan
- Plans must authorize out of network SNF placement when in-network providers do not have capacity
- Members will be allowed to change plans to access a preferred SNF
Long-Stay SNF Services Contracting

<table>
<thead>
<tr>
<th>Counties</th>
<th>Contracted SNFs per County</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings, Queens, Bronx, Suffolk, Nassau, Westchester, Erie, Monroe</td>
<td>8</td>
</tr>
<tr>
<td>New York, Richmond</td>
<td>5</td>
</tr>
<tr>
<td>Oneida, Dutchess, Onondaga, Albany,</td>
<td>4</td>
</tr>
<tr>
<td>Broome, Niagara, Orange, Rockland, Rensselaer, Chautauqua, Schenectady, Ulster</td>
<td>3</td>
</tr>
<tr>
<td>All other counties</td>
<td>2 where available</td>
</tr>
</tbody>
</table>

Plans must contract with 2 of each specialty SNF per county
- HIV
- Vent
- TBI
- Neuro

* FIDA requiring 8 long term SNF providers per county

Provider Contracting

- All agreements must be negotiated in good faith

- All Agreements will have the “New York State Standard Clauses for Managed Care Provider/IPA Contracts”

- FIDA contracts will include Medicare standard clauses

- Due process rights must be included for providers that allow the provider to appeal any determination identified by the MCO
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Contract Basics

- Contract Structure
- Sections
- Things To Look For
- What You Can And Can’t Change
Contract Structure

- Cover Sheet
- Terms & Conditions
- Signature Pages
- Standard Clauses
- Appendices or Amendments
- Lobbying or Other NYS Specific Documents
- Credentialing Forms

Sections

- Participating Parties
- Definitions
- Responsibilities of the Provider
- Responsibilities of the Plan
- Compensation & Billing
- Reporting
- Confidentiality
- Records
- Term & Termination
- Arbitration & Dispute Resolution
- Miscellaneous
- Appendices
  - Service Area
  - Lines of Business
  - Covered Services
  - Compensation
What To Look For When Contracting

Participating Parties
- Your name and address
- Plan’s name and address
- Plan’s licensure

Definitions
- Standard terms defined; e.g.:
  - Clean Claim
  - Participating Provider
  - Medical Necessity

Responsibilities of the Provider
- Licensure
- Credentialing
- Insurance
- Care Management Participation
- Quality & Performance Improvement Participation

Responsibilities of the Plan
- Licensure
- Insurance
- Payment
- Quality and Utilization Review

Compensation & Billing
- Payment Terms
- Coordination of Benefits
- Claim submission timeframes
- Denial timeframes
- Appeals & Grievances
- Hold Harmless

Responsibilities of the Provider
- What information must you report to the plan
- How frequently
- Can you do it? Will it require additional or new resource
**What To Look For When Contracting**

<table>
<thead>
<tr>
<th>Confidentiality</th>
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<table>
<thead>
<tr>
<th>Records</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Term and Termination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contract term</td>
</tr>
<tr>
<td>• Early exit clauses</td>
</tr>
<tr>
<td>➢ Plan Initiated Termination</td>
</tr>
<tr>
<td>➢ Provider Initiated Termination</td>
</tr>
<tr>
<td>➢ Mutual Termination</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Arbitration &amp; Dispute Resolution</th>
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<tbody>
<tr>
<td>• Indemnification</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Miscellaneous</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Audits</td>
</tr>
<tr>
<td>• Amendments</td>
</tr>
<tr>
<td>• Assignability</td>
</tr>
<tr>
<td>• Non-solicitation</td>
</tr>
<tr>
<td>• New product lines</td>
</tr>
</tbody>
</table>

**Appendices**

| • Service Area         |
| • Lines of Business    |
| • Covered Services     |
| • Compensation         |
|   ➢ Exclusions         |
|   ➢ Add-ons            |
|   ➢ Bonuses            |
Reviewing The Provider Manual

- Review all identified manuals
  - e.g. provider manual, member handbook, quality improvement programs
- Provider Manual typically contains detailed information on:
  - Contact Information
  - Product Lines
  - Member Benefits & Responsibilities
  - Provider Rights & Responsibilities
  - Credentialing
  - Pre-Authorization - Utilization Management – Process
  - Appeals Process for Denied Services (on Pre-Auth or post provision)
  - Utilization Management
  - Billing and Claims Process
  - Post-Claims Process
  - Quality Management & Data Reporting

What Can And Can’t You Change

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOH Standard Clauses</td>
<td>Timeframes</td>
</tr>
<tr>
<td>CMS/Medicare Standard Clauses</td>
<td>Terms and Conditions</td>
</tr>
<tr>
<td>Certification Forms</td>
<td>Rates</td>
</tr>
<tr>
<td>Credentialing Requirements</td>
<td>Just About Everything Else!*</td>
</tr>
</tbody>
</table>

* If the plan claims that your requested change is a “material change” it may require DOH approval
Are You Being Delegated Credentialing?

- Plans must credential the SNFs and their providers
- Credentialing of SNF staff may be delegated to the SNF
- MCOs must verify that the SNFs credentialing process complies with Federal and State requirements

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**Benchmark Rates**

- The benchmark rate will include all aspects of the Nursing Homes reimbursement for a FFS patient, including but not limited to Operating, Capital, Case Mix, Cash Assessment, Bed-hold and Quality
- The benchmark rate will be updated and published on the DOH Public Website at least twice a year [https://www.health.data.ny.gov](https://www.health.data.ny.gov)
- The contracting process should include the benchmark rate

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**Quality Pool & Published SNF Rates**

- Quality pool for 2013 is estimated to be $50M
- MCOs will include the quality pool score into their reimbursement
- The published SNF long-term rate cost components include

<table>
<thead>
<tr>
<th>Non Medicare Direct Component</th>
<th>Misc Per Diem Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Eligible Direct Component</td>
<td>Bed Hold Per Diem Adjustment</td>
</tr>
<tr>
<td>Indirect Component</td>
<td>Case Mix Percent Adjustment</td>
</tr>
<tr>
<td>Non-Comp Component</td>
<td>Bed Count</td>
</tr>
<tr>
<td>Capital</td>
<td>Cash Receipts (CRA) Per Diem</td>
</tr>
<tr>
<td>TBI, BMI, Dementia Add On</td>
<td>Total Payment for NH Rate + CRA</td>
</tr>
<tr>
<td>Transition Adjustment</td>
<td>NHQP (Quality) Adjustment - <strong>Not Yet Approved</strong></td>
</tr>
<tr>
<td>Quality Adjustment</td>
<td>Transportation In Direct Price</td>
</tr>
</tbody>
</table>
**NAMI**

- It is anticipated that NAMI will be collected by the Plans, however, *Plans may delegate the responsibility to the NH via the contract process as currently allowed under MLTC*.

- Upon the completion of the chronic care budgeting the Local District will notify the Plan of the NAMI amount to facilitate the collection process.

- Distribution of the Personal Needs Allowance should be coordinated between Plans and providers during the contracting process.

- In the future, the State is proposing to take over the collection of the NAMI for NH residents.

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**Capital**

- DOH is confident that CMS will approve the three year transition proposal related to the operating and capital components, and additionally, the continuation of capital component of the benchmark beyond the three year period.

- This current proposal is intended to maintain stability and provide Nursing Homes with the resources to continue to pay long term debt commitments and access capital markets for future investments.
### Retroactive Rate Adjustments

**Case Mix**

- The FFS benchmark rate will be updated at a minimum of twice a year to account for case mix updates.
- MCOs will be responsible for ensuring that any retroactive changes to the benchmark rates will result in a payment to Nursing Homes that are utilizing the rate in their contracts.
- Plans and providers who choose to negotiate an alternate payment arrangement that is not based on the benchmark will likely avoid retroactive payments.

### Bed Hold

- MCOs are required to continue following the current methodology during the transition period unless an alternative is negotiated.
  - Reserved bed days related to leaves of absence for temporary hospitalizations shall be made at 50% of the Medicaid FFS rate.
  - Reserved beds related to non-hospitalization leaves of absence shall be at 95% of the Medicaid rate.
Shared Savings

- DOH is encouraging Plans and providers to work toward alternative payment arrangements, rather than FFS

- Shared Savings is being encouraged between all Plans and providers and has been included as a proposal in the 2014-15 Executive Budget

- All Plans and providers participating in the Fully Integrated Dual Advantage (FIDA) Demonstration will be encouraged to enter into Shared Saving arrangements

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**Payment Model Concepts**

- **Full Risk**
  - Assumes full financial responsibility for the profit and the potential loss in serving members.

- **Partial Risk**
  - Assumes some financial responsibility for the profit and the potential loss in serving members.

- **Gain Sharing**
  - Assumes some financial responsibility for the profit and none for the potential loss in serving members.

- **Performance Bonuses**
  - Conditional income, paid out only if certain operational, quality or financial measures are met.

- **Capitation**
  - Lump sum payment for each enrolled member, per period of time, whether or not that person seeks care or uses services.

- **Fee-for-Service**
  - Conventional reimbursement for every service provided.

**Case Study #1**

- **What**
  - MLTC and Fee for Service Medicare

- **Who**
  - All new long-stay dual eligible SNF entrants as of 10/1/14

- **Where**
  - Throughout NY State

- **When**
  - As early as tomorrow

- **How**
  - Medicare FFS
  - MLTC capitation
  - MLTC pays a performance bonus on quality measures
Case Study #2

**What**
MLTC and iSNP

**Who**
Any long stay dual eligible - voluntary

**Where**
Throughout NY State

**When**
As early as tomorrow

**How**
- Medicare capitation & risk
- MLTC capitation
- MLTC pays a performance bonus on quality measures
- Medicare pays a performance bonus on quality measures

Case Study #3

**What**
FIDA

**Who**
Any long stay dual eligible - voluntary, opt out

**Where**
Metro NYC area

**When**
Mid to late 2014

**How**
- Coordinated premium and benefit package
- Full risk
**What To Expect After 3 Years**

You should be preparing for now

Cost accounting; what prices can you afford

Free market pricing; unclear if DOH will set a rate floor

Capital continues

Quality score with teeth tied to reimbursement

---

**Questions?**

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