STRATEGIES FOR NEGOTIATING MANAGED CARE CONTRACTS

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DHCF
Department of Health Care Finance

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AGENDA

1. Determining Leverage Points
2. How to Read and Evaluate an MCO Contract
3. Negotiating Tips and Tactics

Learning Objectives

1. Identify potential leverage points for negotiating with Medicaid MCOs
2. Apply a tool for reading and reviewing a managed care contract
3. Implement non-adversarial, collaborative negotiation strategies

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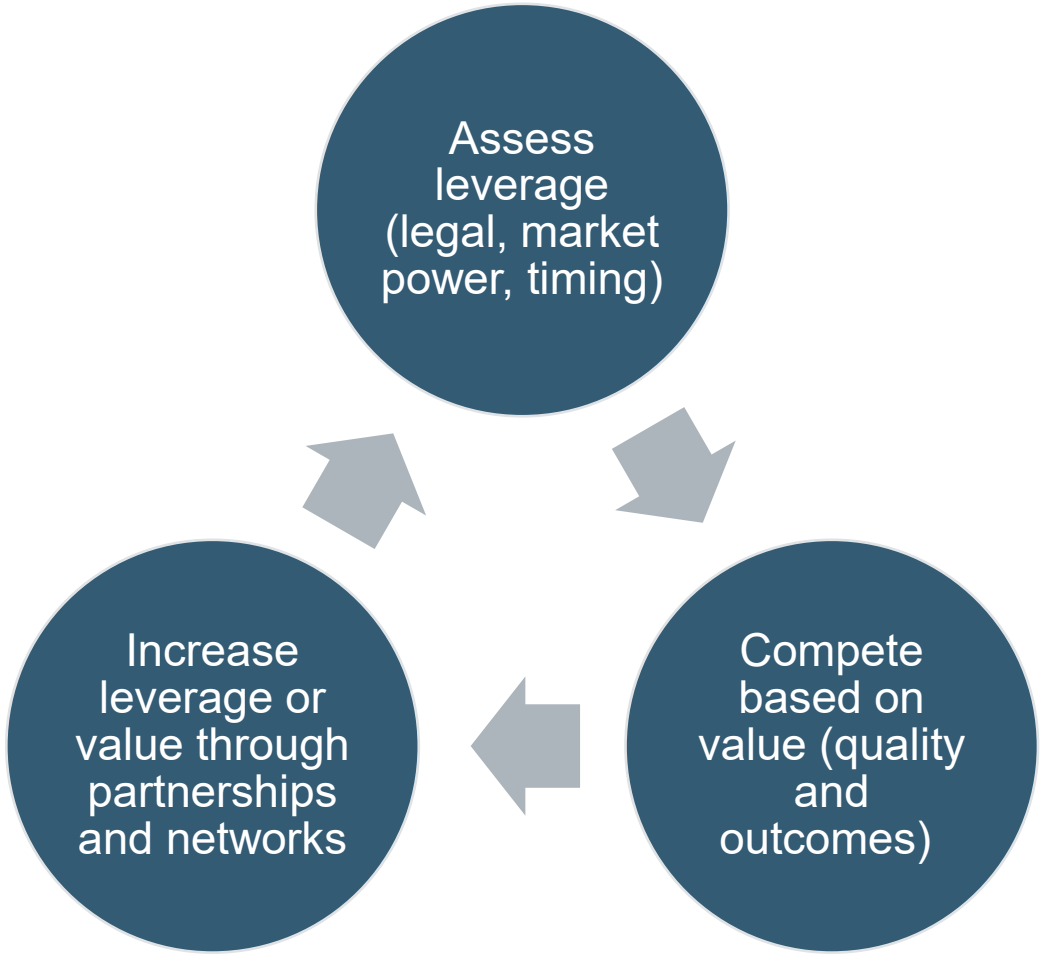
PART ONE:
DETERMINING LEVERAGE POINTS

STEP 1: APPROACHING A NEGOTIATION BASED ON ASSESSING STRENGTHS

- Contract should serve and align interests of both parties
- Each party has something to offer, and each party has its own objectives for pursuing a contract
- Approach negotiations with a solid sense of your objectives, your strengths, and your gaps
- Example
  - Objective to improve quality metrics
  - Strength in service model to achieve quality metrics
  - Gap in infrastructure to adequately report
  - What do you need? What will you offer?

IDENTIFY YOUR STRENGTHS



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ASSESSING LEVERAGE: TIMING

Leverage Points:

- Is the MCO establishing a new provider network or product?
- Does the MCO face critical deadlines in order to enter marketplace by a certain date?

Review Applicable Timelines:

- When is the start date for the applicable product offering (e.g., January 1?)
- What is the deadline for the MCO contracting with providers?
- Ask your trade and professional associations for guidance!

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ASSESSING LEVERAGE: MARKET POWER

- **Potential Leverage Points:**
  - Does the MCO have alternative providers in the market if it does not contract with me?
  - Can the MCO meet applicable network adequacy requirements without me?
- **Conduct Market Analysis**:
  - What organizations (if any) furnish similar services to me?
  - For each of my services, what percent of the market do I serve as compared to other organizations?
- **Hint: Fewer providers = Greater leverage**
  - Assess breadth and scope of services
  - Analyze market share
  - Consider brand and reputation

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ASSESSING LEVERAGE: LEGAL

Potential Leverage Points:

- Participation: Is the MCO required to include me in its provider network?
- Coverage: Is the MCO required to cover (all of) my services?
- Payment: Is the MCO required to pay me a specific rate for services?

Review Applicable Legal Rules:

- MCO contract with the DC Department of Health Care Finance (often referred to as the "Model Contract"), e.g., Managed Care Organization - MedStar

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DC MCO MODEL CONTRACT

C.5.29. Provider Network and Access Requirements

C.5.29.7.3 - Hospitals

- At a minimum, the [MCO] shall have and maintain hospital agreements with all current and future District acute care hospitals and hospital related provider groups in conjunction with 29 DCMR 9415 and which currently include: Howard University Hospital, Medstar Washington Hospital Center, Medstar Georgetown Hospital Children's National Hospital, United Medical Center, Sibley Hospital, and George Washington Hospital.
- The [MCO] shall also include Sheppard Pratt Health System, which provides services for mental health, substance use disorder, special education, developmental disability, and social services, or a hospital providing comparable services approved by DHCF, in its network.

C.5.36.4 – Reimbursement to Hospital Providers

- The [MCO] shall reimburse District hospitals a minimum of 100% of the Medicaid APR-DRG fee schedule for services provided to DCHFP enrollees only, as described in Section C.5.29.7.1, per the DHCF FFS rate methodologies determined by DRG base rates, DC Medicaid FFS case weights and outlier methodologies.
- The [MCO} shall reimburse outpatient services no less than 100% of the DC Medicaid EAPG rate methodology for services provided to DCHFP enrollees only. This provision does not apply to Alliance and ICP enrollees.

Source: https://contracts.ocp.dc.gov/contracts/attachments/Q1c5OTkzMcKmQmFzZSBQZXJpb2TCpns3RUQ1MjU4Qi1CQ0FDLTQ5RkMtODZGQS1CNjBFQkE1QjU2N0F9

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C.5.29. Provider Network and Access Requirements

C.5.29.9 – FQHC Providers

- The [MCO] shall contract with all FQHCs and FQHC look-alikes located in the District of Columbia to provide services to DHCFP, Alliance and ICP Enrollees.

- The [MCO] shall reimburse FQHCs and FQHC look-alikes at the established DHCF Prospective Payment System (PPS) rate or the Alternative Payment Methodology (APM) rate, in accordance with DCMR Chapter 45, Title 29.

Source: https://contracts.ocp.dc.gov/contracts/attachments/Q1c5OTkzMcKmQmFzZSBQZXJpb2TCpns3RUQ1MjU4Qi1CQ0FDLTQ5RkMtODZGQS1CNjBFQkE1QjU2N0F9

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COMPETING ON VALUE

- Sometimes referred to as "competitive advantage", competing on value enhances your negotiating position because you can offer something of greater value than your competitors in the marketplace.

Source: Society for Humanistic Psychology

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IDENTIFYING VALUE: SELF-ASSESSMENT

Can you deliver greater value (potential cost-savings) to the MCO than other providers?

COMMUNICATE YOUR VALUE!

- Marketing materials that communicate the value you offer to MCO.
- In-person meetings with MCOs to describe cost and clinical outcomes.
- Participation at conferences that highlight your achievements.
- Informal networking events.
- Community events.

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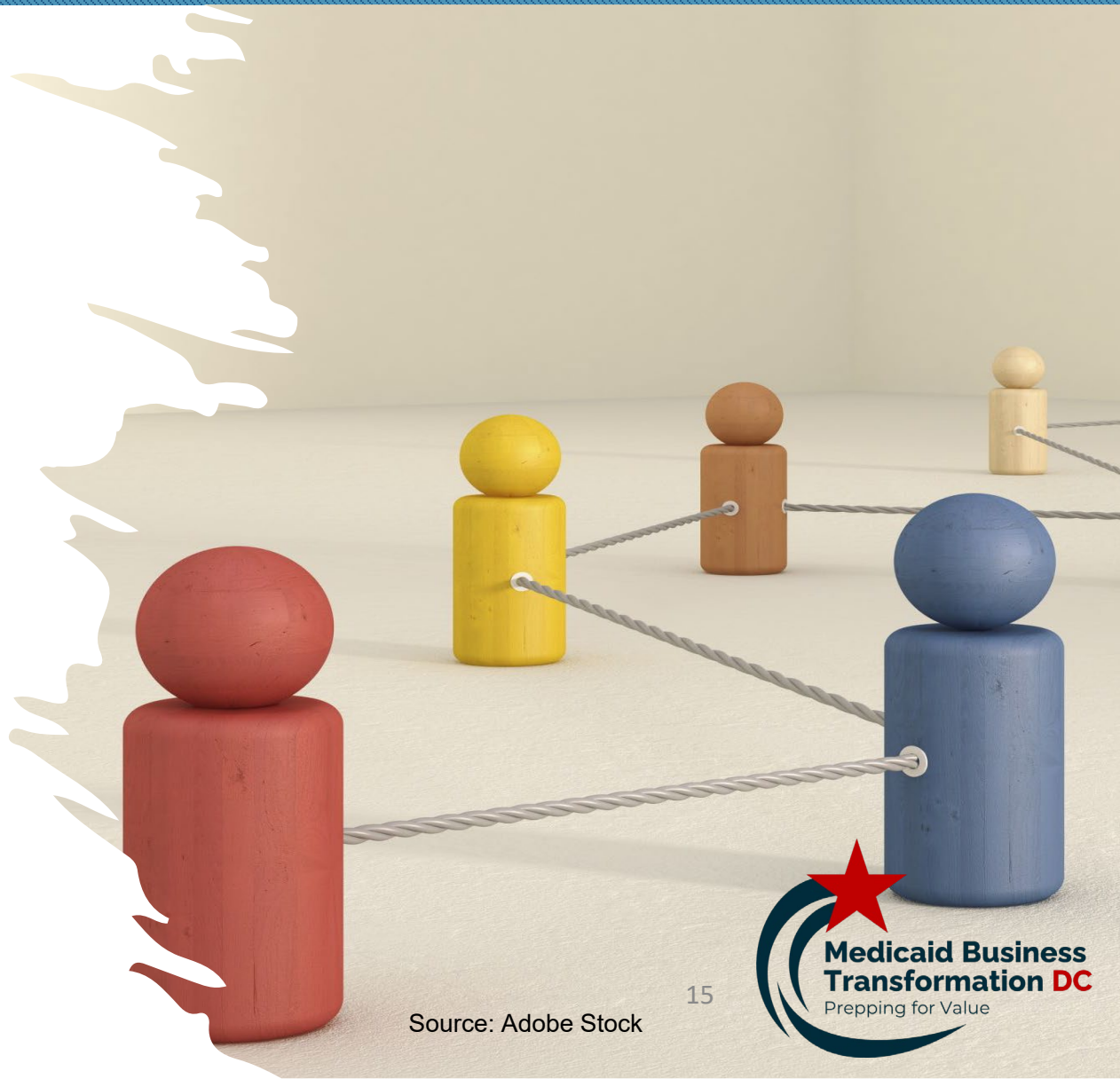
INCREASE LEVERAGE OR VALUE

- Collaborations with other providers through joint ventures or integrated provider networks may increase leverage in the marketplace, enhance your value, or both, thereby improving your negotiation position.



Source: Adobe Stock

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VALUE OF A PROVIDER NETWORK

Source: KPMG

- Provider networks can add scale and leverage with MCOs, community partners, and vendors to expand the capacity, effectiveness, and efficiencies of providers working to implement population health strategies and succeed under value-based reimbursement models.
- A provider network can:
  - Enable providers to participate in sophisticated value-based payment arrangements beyond what they might be able to do on their own.
  - Leverage both size and geographic coverage that the network brings to the payer.
  - Secures data and the means of analysis to support it.
  - Serve as a platform for creating consistency in provider operations in order to raise performance for all, and pools financial resources to support this work.
  - Elevate the profile of providers with health plans and other payers, providing concrete ROI information that can also be used with policymakers (state and federal).
  - Enable providers to expand their current offerings to their patients and expand their capacity to treat patients in their community.

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INTEGRATED CARE FINANCING MODELS (PROVIDER NETWORKS)

INTEGRATED CARE FINANCING MODELS (PROVIDER NETWORKS)

Multi-Provider Type Networks

PART TWO:
HOW TO EVALUATE AND READ A MANAGED CARE CONTRACT

EVALUATING A MANAGED CARE CONTRACT

1) **Negotiate the timeframe for review**

   - Do not assume the contract is offered on a "take it or leave it" basis
   - Explain that you have a due diligence process for all contracts before signing.

2) **Assemble your contract review team**

   - Establish a “point person” and review team lead.
   - Assign areas of contract review to team members based on their expertise.

Source: UN Sustainable Development Group

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3) ASSESS THE MCO'S OPERATIONAL PERFORMANCE

» **Consider past performance of the MCO.** If possible, gather information about past experience of the provider with this MCO:

- Did the MCO meet its payment obligations on time?
- Was the basis for denied claims reasonable?
- Did the MCO give the provider a role in the development of policies, such as utilization review?
- Was the MCO responsive to the provider's requests?

Source: SHRM

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4) ASSESS THE MCO'S FINANCIAL STABILITY

- **Evaluate the MCO's background and fitness.** If possible, the provider should examine the following elements of the MCO's operation:
  - Financial stability and strength.
  - Administrative record.
  - Operational methods.
  - Structural framework.
- Hint: Review MCO's financial statements filed with the National Association of Insurance Commissions, available at: https://content.naic.org/industry/insdata

Source: LinkedIn

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HOW TO READ A MANAGED CARE CONTRACT

Start at the end.

- Locate the exhibits, attachments, and addenda at the end of the agreement.
- Identify the required services (i.e., your scope of services), payment rates and methodologies, and products/plans/lines of business (e.g., Medicaid, Medicare, commercial, and exchange).
- Confirm the scope of services is correct, that the payment rates have been included or referenced (i.e., Medicaid rates), and that it includes participation in all of the MCO's products/lines of business that you want.

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HOW TO READ A MANAGED CARE CONTRACT

- Go back to the beginning and review the introductory paragraph on the contract.
  - Confirm that it correctly states your legal name, type of legal entity, and mailing address.
  - Confirm the Effective Date or Start Date, if stated.
- Skip the “definitions” section (for now).
  - Any capitalized term in the contract will always be a defined term (though the term will not always have been defined in the definitions section!).

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EVALUATING A MCO CONTRACT: PRACTICE POINTERS

- **Remember which party drafted the contract.**
  - If something seems unfair or completely one-sided, then point it out and request that the provision be revised to benefit both parties.
  - If something seems unclear or confusing, ask what it means, and ask the term be clarified to reflect that meaning.
- **Compare the various MCO contracts against each other.**
  - Each MCO will have its own contract templates and contracting styles.
  - Some will contain more favorable language than others.
- **Don’t confuse regulatory approval of the contract template with endorsement of the contract.**
  - Regulators expect MCOs and providers to negotiate terms.
  - Obtaining regulatory approval for contract changes (if required) is the MCO’s responsibility, not yours.

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TOOL

- This is a self-assessment tool intended to help health care providers plan for negotiations around proposed managed care contracts. The tool can be used for internal conversations to analyze key terms, develop strategic direction, and set priorities for approaching negotiations. This tool can help providers determine if they are ready to contract, what level of risk they can tolerate, and what areas to focus on in negotiations.
- The tool will be added to the Integrated Care DC Learning Library: https://www.integratedcaredc.com/learning-library/

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Prepping Health Care Providers for Medicaid Managed Care Organization Contract Negotiations

How to use this tool:

1. This tool can be used for conducting a self-assessment before entering discussions with Medicaid managed care organizations (MCOs) related to contracting and/or utilizing value-based payment arrangements. It can help answer the following:
   a. What is your level of readiness?
   b. What level of risk can you tolerate?
   c. What are the benefits of contracting?
   d. What are areas for collaboration?
   e. What are areas for agreement?
   f. What are your options for negotiating?
2. You have OPTIONS to determine what level of specificity serves mutual interests. There are legal benefits and risks associated with the level of detail included in the contracts. For example, there may be metrics for success related to value-based payment arrangements. You may choose to include the metrics or leave them open to be decided later or independently. You will need to evaluate the risks related to the level of specificity included in the contract terms.
3. Internal assessment should support and provide a basis for business planning, some of which may be necessary before and during the negotiation process.
4. Themes for negotiations and self-assessment are divided into four categories:
   a. Your own and mutual responsibilities
   b. Payment arrangements
   c. Contract implementation
   d. Contract review

PART 3:
NEGOTIATING TIPS AND TACTICS

STEP 3: NEGOTIATING TIPS AND TACTICS

- Your idea of negotiation?

Source: Virginia Tech

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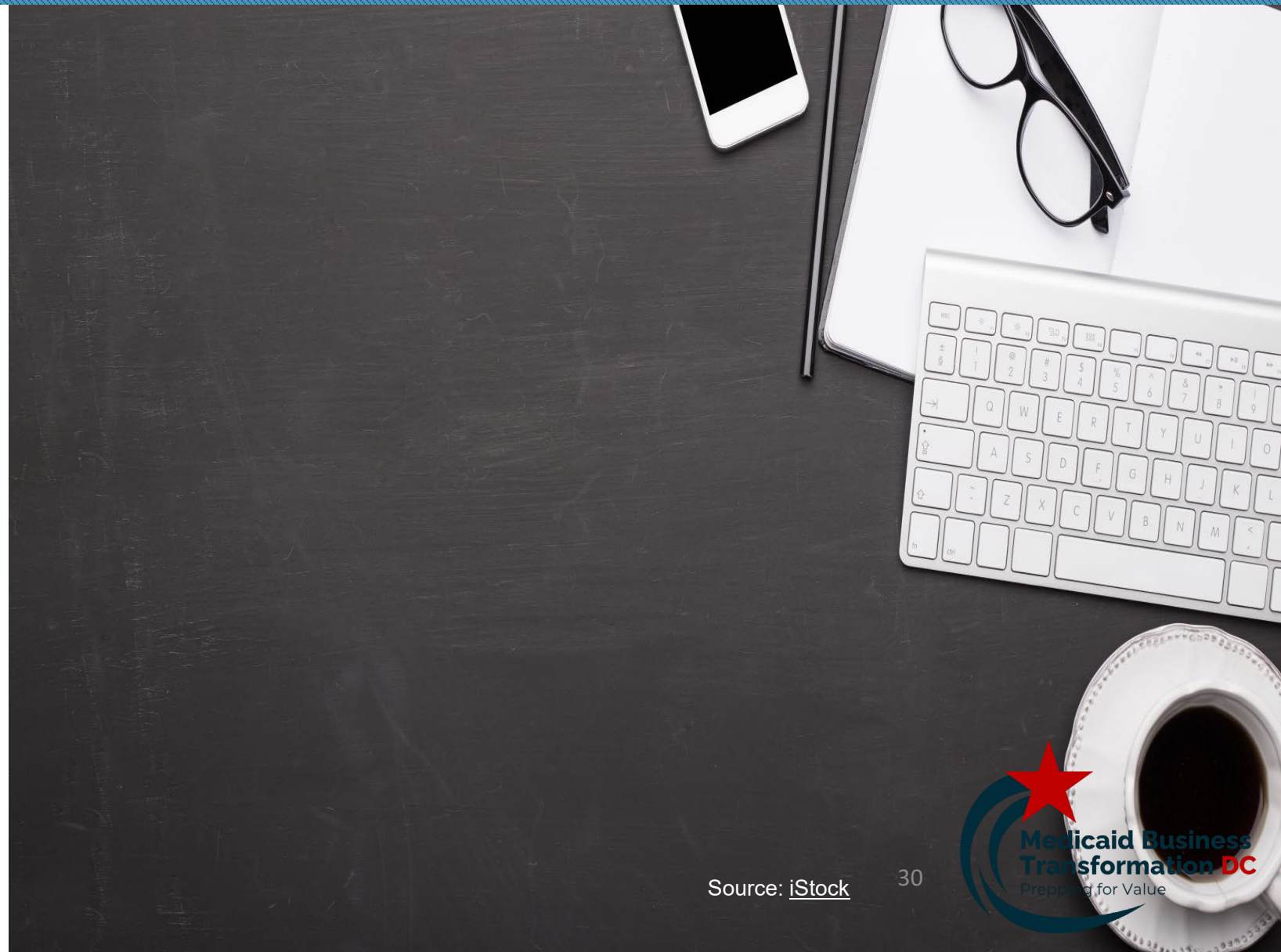
WHAT'S NEGOTIATION?

- Reframe negotiation as discussion aimed at reaching agreement.
- Fisher, Roger; Ury, William; Patton, Bruce (2011) [1981]. Getting to Yes: Negotiating Agreement Without Giving In (3rd ed.). New York: Penguin Books.

Source: Adam Falcone

PRELIMINARY PROCESS QUESTIONS

- Who will be negotiating?
  - A team?
  - An individual?
- How will issues be negotiated?
  - In writing?
  - By phone?
  - In person?



Source: iStock

A COMMON ERROR IS BARGAINING OVER POSITIONS.

Occurs when one or both parties get stuck in ensuring that they win on their positions, regardless of whether the overall goal is attained.

Occurs when parties take extreme positions with the expectation that they will have room to bargain down.

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NEGOTIATING TIPS

Educate

Do not assume that the MCO's representative understands your concerns.

Learn

Respond with questions, rather than statements, and respond specifically to the MCO’s concerns.

Voice

Voice options for mutual gain and generate a variety of possibilities before deciding what to do.

Identify

Identify mutually agreeable objective standards, if possible.

State

State the importance of maintaining an ongoing relationship.

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SUMMARY OF KEY POINTS IN TODAY'S WEBINAR

Step 3

WRAP-UP/NEXT STEPS

BRIEF EVALUATION

1. Overall rating:

1. Poor 2. Fair 3. Average 4. Good 5. Excellent

2. Content Level:

1. Too Easy 2. Just Right 3. Too Advanced

3. Which TA modalities are you interested in for additional TA? *(Select all that apply)*

1. Webinars 2. Individual Coaching 3. Group Coaching

4. Which domains are you interested in receiving additional TA in? *(Select all that apply)*

1. Financial 2. Clinical 3. Legal 4. Business

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UPCOMING SESSIONS & MORE INFORMATION

Upcoming Cohort Sessions:

- **Understanding Key Terms in Managed Care Contracts**
  (Aug. 17, 12 – 1 pm ET)
- **Where Quality Meets Legal**
  (Aug. 30, 1 – 2 pm ET)
- **Key Considerations for Value Based Payment Arrangements**
  (Sept. 19, 12 – 1 pm ET)

Visit the Medicaid Business Transformation DC web page for more information and upcoming events:

www.integratedcaredc.com/medicaid-business-transformation-dc/

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