Issues HCBS Providers may Negotiate with Health Plans: Key Considerations for Providers

As more states shift to managed long-term services and supports (LTSS) for their Medicaid programs, your organization may need to contract with health plans. Health plans may be accustomed to contracting for institutional-based acute care services but may not have as much experience with the LTSS that you deliver, often in the community. This brief outlines key issues that may be addressed and negotiated in the contract the health plan offers you. Although the state may specify many of these issues in its contract with the health plan, there still may be flexibility around how the health plan actually implements them.

Key Contract Issues

- **Scope of services.** You may wish to negotiate the scope of services covered by the health plan. Consider the following examples of questions to consider:
  - Does your organization provide services or innovative models the health plan has not considered in its contract but that are important to your clients?
  - Does your organization provide services consistent with the overall goals of the health plan but that do not meet the specific criteria outlined in the contract?
- **Qualifications of workers.** Health plans may define the types, categories, credentials, or training of providers who deliver certain services. Your organization may wish to negotiate the inclusion of programs staffed by workers with qualifications that fall outside those definitions. For instance:
  - The health plan may require licensed practical nurses to perform all home health services. However, you may have found that certified home health aides successfully meet the home health needs of many clients.
- **Rates and payment model.** Your organization will want to negotiate payment rates consistent with your cost structure. Health plans may want to change the way you are paid by incorporating some risk sharing or shared savings. These approaches are intended to provide incentives to deliver services efficiently by holding providers accountable for some costs that are higher than expected or by rewarding providers when costs are lower than expected. You will want to carefully evaluate any risk sharing or shared savings approaches to ensure that your organization can meet the efficiency expectations.
- **Billing processes.** Health plans will specify the process you must follow to bill them for the services you have provided. This may include requiring you to submit claims electronically or to use specific codes for identifying the services and to track service use. There are often limits on the number of units, visits, etc. by provider. You may sometimes be able to negotiate those processes or ask health plans to cover the cost of training and equipping your organization to comply with them. For more information, see the Billing for Services brief.

- **Implementation schedule.** Your organization will want to make sure you are ready to begin the contract when all administrative processes are in place, staff is trained, and you understand all new requirements. The initiation of the contract is subject to agreement of both parties.
- **Incentives and interest payments related to clean claims.** Health plans often pay only "clean" claims – or claims that meet certain health plan-defined criteria. Upon being presented with a health plan contract, your organization may want to carefully examine the definition and payment criteria associated with clean claims and ask the following questions:
    - Is the health plan definition of a clean claim consistent with yours? Are there incentives for consistently submitting clean claims? Is interest accrued on clean claims that are not paid by the health plan within a defined period? Is there an appeals process?

  If the answer to any of these questions is "no," these are areas you may choose to discuss or negotiate with the health plan.
- **Support for training and credentialing.** Training and credentialing programs for your providers can be expensive and time-consuming. As such, you may consider asking the health plan to cover some or all of the costs associated with meeting staff training and credentialing requirements and learning new billing and coding procedures and other new business requirements. Such support could come in the form of directly reimbursing for the cost of training and credentialing programs required by the health plan or providing training for back-office staff around claims submission processes and coding.
- **Pre-authorizations.** Many health plans require that some services be approved prior to delivery. You may wish to negotiate the services that will require advance approval (pre-authorization or prior-authorization) and discuss conditions for covering services, such as a peer support responding to a client in crisis.
- **Quality and reporting.** Various health plans may require you to report quality and performance metrics. The National Disability Rights Education and Defense Fund offers a document outlining quality and outcome metrics you might expect to see in health plan contracts.
- **Additional resources.** The Centers for Medicare & Medicaid Services offer more information in two papers:
    - Transitioning Long Term Services and Supports Providers Into Managed Care Programs
    - The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update

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