Contracting with Health Plans: Key Considerations for Providers

Many states are implementing managed long-term services and supports (LTSS) to better coordinate care for Medicaid recipients. This may change the way your organization provides Medicaid services by requiring you to contract or enter into an agreement with one or more health plans rather than directly with the state. Working with health plans might be a new experience for you or your organization. Similarly, health plans may have limited or no experience working with LTSS providers. This brief outlines general considerations for organizations such as yours when contracting or entering into agreements with health plans.

Key Considerations

- **Seek out opportunities to meet with your state officials and health plans to learn about your state's managed LTSS program.** There are often stakeholder meetings and focus groups open to LTSS providers. Through participating, your organization may be able to provide feedback to state officials and health plans on the design of the managed LTSS program and the various responsibilities for the health plans and the LTSS providers under these new arrangements. Your organization may learn about additional technical assistance or training opportunities.
- **Prepare to negotiate the terms of participation with the health plan.** Your organization should prepare to negotiate with the health plan by first understanding the state and the plan requirements. Then assess your organization's ability to meet those requirements. In addition, it would be useful to:
  - **Evaluate your cost structure.** Evaluating your cost structure and your costs for providing each of your services will help in negotiating appropriate fees. You may need to establish a clear fee schedule covering the scope of potential services and your basis for quantifying services performed (e.g., miles driven, hours of assistance, meals prepared).
  - **Ensure you completely understand the plan's billing requirements.** Health plans typically require providers to use standard medical claims forms. The information the plan requires for paying bills may differ from those that your organization is used to providing. To ensure timely processing and payment, make sure you understand all aspects of the billing process including the information you need to submit to the plan.
  - **Understand the state's requirements for how the plans must contract with providers.** States may establish the basis for plan payments to providers. For example, some may require plans to

Understand Which Health Plans are Contracting with Your State

Your organization can identify the health plans that will manage LTSS from your state's Medicaid website or by calling the Medicaid agency. The Medicaid agency can provide information on the populations that the health plans will be managing and the services they will cover. Relevant requests for proposals (RFPs) will provide valuable background on how health plans are expected to administer LTSS programs within the state, including beneficiary protections, continuity of care requirements, and contract rules. These RFPs are often available on your state's Medicaid website.

pay a base rate for particular services, with various adjustments, or that plans pay no less than the state had paid. States may require plans to ensure that members can maintain their current direct service workers.

- **Review the provider manual.** Be sure that the plan's requirements for participation, claims submission, and payment are conveyed in writing, such as in the provider manual, and that the provider manual becomes part of your contract or agreement through reference.

- **Consider how the health plan can support your organization.** The health plan is responsible for ensuring that its providers have the resources and information to provide quality care to its members. Your organization may suggest opportunities for the plan to help improve your ability to provide care. This may include requesting concrete assistance in claim submission processes, updating methods for sharing relevant information across all providers, or training on the needs of clients with particular conditions or diagnoses.
- **Work with the plan's provider relations or care coordination staff to ensure timely communication.** Your organization will want timely updates on your clients' services and coverage as well as health plan policies. Identify the individuals in the health plan who will communicate service authorizations for your clients and will notify you if any of your clients change plans. Although most plans have provider manuals and conduct outreach to inform providers of any policy updates, you may want to suggest ways the provider relations staff can ensure that your organization has this information in real-time. Plans may have the ability to alter their communication strategies based upon your internet access, IT capacity, staffing, or other considerations.
- **Consider opportunities for working with community-based organizations.** Organizations such as aging and disability resource centers, area agencies on aging, provider associations, or patient advocacy groups may be able to provide support and technical assistance in helping your organization or your clients in making a successful transition to managed LTSS.
- **Take advantage of the opportunity to work with the health plan.** Your organization brings first-hand knowledge of your clients and their needs as well as knowledge of state-specific programs such as participant-directed services. Use this information to work with the health plan to improve how care is delivered, better support and meet the needs of your clients, and implement efficiencies in care delivery.

The Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare & Medicaid Services (CMS) seeks to help beneficiaries dually eligible for Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. This brief is intended to support health plans and providers in integrating and coordinating care for dually eligible beneficiaries. It does not convey current or anticipated health plan or provider requirements. For additional information, please go to https://www.resourcesforintegratedcare.com/