Key Contract Components: Considerations for Providers

More states are contracting with health plans to manage Medicaid long-term services and supports (LTSS). As a result, you may find yourself working with health plans instead of the state to provide care for your Medicaid clients. Contracting with a health plan may be a new experience for your organization. Although contracts, also referred to as agreements, between health plans and providers will vary, they will probably contain similar components. This brief outlines key components of a contract or agreement for becoming a participating provider with a health plan.

Key Considerations

- **Parties to the contract.** Your contract or agreement will list the specific parties you will be working with. The health plan may actually be a part of a larger organization. Be sure you are clear on the specific party you are contracting with.
- **List of definitions**. While this may seem a straightforward component of your contract, the initial list of definitions will establish a framework for the entire contract. Pay particular attention to how the health plan defines terms such as “clean claim,” “covered services,” “medically necessary,” and “emergency care.” These terms help define which services you will be paid for providing and which services will not be covered.
- **Covered services**. Your organization will need to work with the health plan to establish what services you will provide under the contract. The services that are covered, or paid for, under the contract may differ from those you provided under previous arrangements. Your organization will want to review:
  - **Prior-authorization.** Some of the services included in your agreement may require health plan approval before they will be covered (prior-authorization). Knowing what services will require prior authorization is critical to ensuring appropriate scheduling, maintaining continuity of care, meeting the needs of your clients, and ensuring timely and complete payment for services rendered.
  - **Service delivery.** For each covered service, the health plan should define how it will be delivered, the type and amount of care to be provided, the length of service (the number of days between the beginning and end of providing the service), and the units (number of visits or services). While prior-authorization may determine this for some services, you may want to negotiate with the health plan to ensure that definitions of services are consistent with your clients’ needs and your standards of care.
- **Care coordination procedures**. Your organization may need to follow specific care coordination procedures defined by your health plan. Procedures may include working with caregivers and family members, providing health education, communicating with the health plan, coordinating care with other providers, and ensuring communication between your organization and other providers as well as the health plan.

- **Payment**. Each contract will specify payment terms. The payment structure may vary between health plans; your organization should carefully review this section to understand claims processing, form of payment, frequency of payment, and billing rates and codes.
- **Provider manual**. Your contract will lay out the health plan's responsibilities to your organization. Your organization may want to pay specific attention to the contract section on provider manuals. The health plan will be responsible for supplying a provider manual to your organization that outlines additional policies, procedures, and expectations. Your agreement with the health plan may specifically include the manual, by reference, as a part of the contract. You may also want to review the provider manual itself.
- **Provider responsibilities**. Your organization will have multiple obligations outlined in several sections of your health plan contract. Your organization may want to pay particular attention to:
  - **Prior-authorization.** Some of the services included in your agreement may require health plan approval before they will be covered (prior-authorization). Knowing what services will require prior authorization is critical to ensuring appropriate scheduling, maintaining continuity of care, meeting the needs of your clients, and ensuring timely and complete payment for services rendered.
  - **Insurance coverage.** The health plan may require professional liability insurance or worker's compensation insurance and unemployment insurance. Your organization should review the health plan's insurance requirements including minimum insurance limits.
  - **Records.** Your contract will have a specific section regarding your organization's obligation to maintain accurate and confidential records and advance directives.
  - **Quality management.** Your organization will probably be obligated to report specific quality indicators to your health plan. Your agreement will outline some expectations for reporting quality indicators; however, the provider manual will include more specific information.
- **Term and termination**. This section will define the initial term (time frame) of the contract as well as the grounds for terminating your organization's relationship with the health plan. Your organization should pay special attention to the criteria for immediate termination as well as the language on termination without cause and dispute resolution. For example, your health plan may have specific procedures in place for resolving disputes, starting with informal conversations and escalating to mediation. This will most likely include specific timeframes as well as specific locations for formal processes like mediation.

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