NORTH CAROLINA AHEC

PRACTICE SUPPORT

Medicaid Managed Care Contracting Tip Sheet

The North Carolina Area Health Education Centers Program (NC AHEC) and North Carolina Medicaid are partnering to offer educational assistance and practice support to healthcare providers transitioning to NC Medicaid Managed Care. Medicaid has made program information and supportive guidance available at https://medicaid.ncdhhs.gov/providers/provider-playbook-medicaid-managed care.

This document was prepared by NC AHEC as an additional resource for providers and is intended to provide practical considerations for participating "in-network" with one or more of the Health Plans serving the state's Medicaid beneficiaries. It is not intended to be legal advice - healthcare providers and practice managers should review the contract proposal and consider consulting with an attorney before entering into a new contract.

Under NC Medicaid Managed Care, the majority of beneficiaries will enroll with (or be assigned to) one of the five health plans awarded a contract by NC Medicaid: (i) AmeriHealth Caritas of North Carolina, Inc., (ii) Blue Cross Blue Shield of North Carolina/Healthy Blue, (iii) Carolina Complete Health, Inc., (iv) UnitedHealthcare of North Carolina Inc., (v.) WellCare of North Carolina, Inc.

Your reimbursement is directly impacted by the beneficiary's selection/assignment and whether you are participating with the health plan as part of its network. If you are in-network, you will receive the agreed upon contracted amount provided you meet all terms and obligations of that contract. If you are out-of-network, the services provided by you are generally reimbursed at a lesser amount and there are no contractual obligations owed or due to either party. The program comprises certain requirements to ensure a degree of certainty to both the providers and the health plans while facilitating limited contract negotiations and opportunities for innovation. As there are pros and cons to this approach, this document outlines some key considerations that may be useful.

Health plan contracts contain certain terms and conditions required by Federal and State law.

- **Medicaid Managed Care is highly regulated by federal and state law.** Medicaid through its RFP process requires all provider and health plan contracts to contain certain terms and conditions. This means there will be many contract provisions that cite federal, state, or agency requirements. These are:
    - Non-negotiable for the most part.
    - Include prompt pay requirements, grievance and appeal rights, and time frames.
    - If the provision merely cites a regulatory requirement, be aware of your obligations.

  - You may find provisions that are not applicable to your specific circumstances but are still included.
  - Note any obligations that extend beyond the contract terms.

What are In-Network vs Out-of-Network Terms?

- Any willing and qualified provider standards still apply. If you wish to be in-network, the health plan cannot exclude your practice indiscriminately. This means you can be a part of one or any number of health plans contracted to provide services in your area.
  - You must sign an agreement with at least one health plan and are bound by the terms of conditions of each agreement independent of the other agreements.
  - Despite efforts for standardization, if you sign with more than one health plans, you must be prepared for potential multiple unique actors, processes, and requirements.
  - Participating in multiple networks mitigates disruption based on patient movement between health plans.
  - Note that you must be enrolled with Medicaid, meet the health plan's objective quality standards, and agree to the health plan's reimbursement rates.
  - You may contract directly with the health plan(s) or via your CIN (Clinically Integrated Network).
- In-network providers may receive rate floor protections currently at not less than 100 percent of Medicaid fee for service rates and have rights to enforce contractual obligations of the health plan.

What should be in the agreement?

- Health plans will prefer to use a universal provider agreement that has been approved by the regulating agencies and therefore will be less inclined to modify the core provisions of the standard agreement.
- Reimbursement rates will initially align with the statutory minimum, and innovative value-based reimbursement opportunities should develop more so over time.
- Much of the functional components of the arrangement are contained in provider policies and manuals incorporated by reference.
- Review the current version and know the process for the health plan to change such policies and at what point in time are you bound by such changes.
- The term of the agreement should be for a set time period. Know what action (if any) is required for extending/renewing the term. Know if and how either party can terminate at any time within the term. Know of your rights and any post termination obligations.

- The Parties of the Agreement may include affiliated companies of the health plan. Know who else may have access or rights under the agreement. Know who and how to communicate with the health plan as to questions or disputes related to the contract.
- Review any agreed upon dispute resolution or arbitration processes to know your limitations in protecting or enforcing your rights.
- If the agreement contemplates participation in more than one network, know how your practice and any provider is added to and removed from additional health plan networks.

In Your Practice:

- Keep a calendar with reminders for contract renewals, periodic visits with the health plan or CIN representative for updates and to share feedback, etc.
- Utilize a spreadsheet and update it accordingly with all plans and payment proposals, utilization rates by health plan, current reimbursement rates, and negotiated rate ceilings needed for success.
- Understand how rates, quality and performance payments and any risk-sharing payments intersect to determine actual payment amounts.
- Learn the health plan's audit process for billing, coding and documentation.
- Know the health plan's policy on timing of payments, including the payment terms during the adjudication process, the consequences of a payment lag and the rights if one occurs.
- Clarify the health plan's definition of a "clean" claim and terms for timely filing of claims at either first submission or resubmission should the claim or part of the claim be denied.
- Determine the administrative impact of participation. Understand all documentation and administrative requirements to align them to the greatest amount possible to reduce administrative burdens. Determine if the practice will need additional resources. Include as part of your workforce planning and training.
- Understand how the health plan uses performance metrics related to quality, cost and care access.
- Know if your EHR can provide data for quality metric reporting that is specified in the contract.
- Understand how the health plan audits your performance with quality metrics.
- Consider if your Advanced Medical Home (AMH) tier 3 practice should contract with a CIN (Clinically Integrated Network).

Need Further Assistance?

Contact NC AHEC Practice Support at 919-445-3508 or practicesupport@ncahec.net.