UNDERSTANDING KEY TERMS IN MANAGED CARE CONTRACTS

The information provided in this presentation does not, and is not intended to, constitute legal advice; instead, all information, content, and materials available are for general informational purposes only.

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Presented By:
Adam Falcone, JD, MPH
Michele Melden, JD

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DHCF
Department of Health Care Finance

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PRESENTER(S)

Michele Melden, JD
Principal
Health Management Associates
mmelden@healthmanagement.com

Adam Falcone, JD, MPH
Partner
Feldesman Tucker Leifer Fidell LLP
afalcone@feldesmantucker.com

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AGENDA

I. Introduction
   - DC Medicaid Contract Requirements
   - Structure of a Typical Managed Care Contract

II. Service Delivery
   - Scope of Services vs. Covered Services
   - Access and Appointment Standards
   - Licensing and Credentialing

III. Payment
   - Claims Submission
   - Prompt Payment
   - Payment Rates
   - Overpayments and Underpayments
   - All Products Clauses
   - Regulatory Penalties

IV. General Terms
   - Term and Termination
   - Amendments
   - Notice
   - Indemnification
   - Dispute Resolution

Learning Objectives

1. Explain the meaning of key managed care contract terms

2. Identify potential legal risks in common contract terms

3. Utilize practice pointers to negotiate more favorable contract terms

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INTRODUCTION

DC MANAGED CARE CONTRACT REQUIREMENTS

C.5.29.26 Provider Agreements

- The Contractor shall have written Provider Agreements with all of its Network Providers.
- In addition to the credentialing requirements described in Section C.5.29.24, the Contractor's Provider contracts shall meet the following criteria:
  - Include a provision requiring Providers' compliance with 42 C.F.R. Part 2, the HIPAA Privacy and Security Rules, and the D.C. Mental Health Information Act (D.C. Code § 6-2001 et seq.);
  - Include a payment dispute resolution procedure that compels binding arbitration or another mandatory form of alternative dispute resolution;
  - Prohibit the Provider from seeking payment from the Enrollee for any Covered Services provided to the Enrollee within the terms of the contract. The contract shall require the Provider to look solely to the Contractor for compensation for services rendered. No cost sharing or deductibles shall be collected from Enrollees;
  - Require the Provider to cooperate with the Contractor's compliance plan and fraud, waste and abuse efforts, CQI and utilization review activities;
  - Include provisions stating that Providers are not prohibited from advocating on behalf of the Enrollee in any Grievance, Appeal, or utilization review process, or individual authorization process to obtain necessary health care services;
  - Include a clear, concise, and understandable description of the Provider's incentive compensation and arrangements;
  - [Note: There are twelve additional criteria not listed here.]

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

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TYPICAL STRUCTURE OF MANAGED CARE CONTRACTS

- Definitions
- Provider Obligations
- MCO Obligations
- Payment
- Confidentiality and Privacy
- Term and Termination
- General Provisions
- Exhibits
  - Products (Medicaid, Medicare, commercial/exchange)
  - Compensation Terms
  - Regulatory Requirements

SERVICE DELIVERY

SCOPE OF SERVICES

MCOs typically contract with a range of providers, each of which furnishes a subset of the full range of services that the MCO is responsible for covering on behalf of the payer.

- The scope of services section of the contract (or contract exhibit) specifies which services the provider is responsible for providing.
  - **Test for under-inclusiveness**: Does the scope of services include all of the services furnished by the provider?
  - **Test for over-inclusiveness**: Does the scope of services exclude any services that the provider does not furnish?
  - **Practice Pointer**: Does the provision require the provider to furnish all services on a 24/7 basis?
- Consider modifying if you cannot comply as written, e.g., allow after-hours answering services to meet obligation.

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COVERED SERVICES

Distinguish the **scope of services** from the enrollee's **covered services** (*i.e.*, the services available under the enrollee's benefit plan).

Services must fall within **both** Covered Services and Scope of Services in order to receive payment from an MCO.

Recognize that Medicaid covered services are often broader than other benefit plans; enrollees can have different covered services, depending upon the benefit plan.

Determine whether there are any significant coverage limitations that apply to services provided.

The contract should make clear that the provider may treat enrollees as private-pay patients for purposes of providing non-covered services.

Review the documentation requirements to bill a patient for non-covered services.

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LIMITATIONS ON SERVICE PROVISION

The contract should clearly state any limits on *how* services can be provided by the provider, including:

- MCOs can impose limitations on which types of clinicians are eligible to furnish certain services.
  - **Practice Pointer**: Review provider manual to identify potential limitations on clinicians to furnish services within their scope of practice.
- MCOs can also impose limitations on the provider's ability to arrange for services through subcontracted providers.
  - **Practice Pointer**: Modify provision to permit exception for contracted practitioners who render services at a provider's location.

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ACCESS STANDARDS

Access standards define the required level and availability of care from a patient-centered perspective, including:

- Required hours and days of operation (including evening and weekend business hours).
- After-hours coverage and on-call coverage when a designated health care professional is unavailable.
- Maximum waiting times for establishing an appointment for various categories of services.
- Maximum waiting-room times.

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DC MANAGED CARE CONTRACT REQUIREMENTS

C.5.29.18 Appointment Time Standards for Services

- The Contractor shall ensure that Enrollees with appointments who arrive by their scheduled appointment time shall not routinely be made to wait more than forty-five (45) minutes from their scheduled appointment time to see a PCP. The Contractor shall monitor Enrollee wait times to make an appointment with the Provider, as well as the length of time the Enrollee actually spent waiting to see the Provider.
- The Contractor shall ensure that its PCPs offer new Enrollees, ages twenty-one (21) and over, an initial appointment within forty-five (45) days of their date of enrollment with the PCP or within thirty (30) days of request, whichever is sooner.
- The Contractor shall ensure that services for the assessment and stabilization of psychiatric crises, including those experienced with treating children or adolescents, are available on a twenty-four (24) hour basis, seven (7) days a week, including weekends and holidays. Phone based assessment must be provided within fifteen (15) minutes of request and, when Medically Necessary, intervention or face- to-face assessment shall be provided within ninety (90) minutes of completion of the phone assessment. These services shall be provided by practitioners with appropriate expertise in mental health with on-call access to an adult or child and adolescent psychiatrist.

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

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ACCESS STANDARDS

Practice Pointers

- Review the access and appointment standards in the contract to determine if they are reasonable and are applicable to your scope of services.
- Consider modifying the obligation so that they apply only “if applicable” to your provider type or scope of services.
- Consider modifying the obligation to permit you to comply with the standards by “making reasonable efforts” to comply with such standards.

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CREDENTIALING – TIMING

Most MCO contracts provide for credentialing at the outset of the contract and at regular intervals

- MCO credentialing of a practitioner must be effective on the date of service in order for the provider to receive payment for services to an MCO enrollee.
- **Practice Pointer:** Consider delaying a new practitioner's start date until credentialed by at least one MCO.

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DC MANAGED CARE CONTRACT REQUIREMENTS

C.5.29.24.– Credentialing

- The Contractor shall ensure that all Providers are credentialed prior to becoming Network Providers and that the Contractor conducts a site visit for all PCP and Behavioral Health Providers before they provide services to Enrollees.
- The Contractor shall re-credential Providers at least every two (2) years, or if the Contractor is NCQA accredited, the Contractor shall re-credential based on NCQA requirements.
- The Contractor shall require that physician Providers and other licensed and certified professional Providers, including Behavioral Health Providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to obtain Continuing Medical Education (CME) credits or Continuing Education Units (CEUs) and participate in other training opportunities, as appropriate for Provider's respective licensure and/or certification.
- The Contractor shall ensure that the Provider credentialing process is completed within one hundred twenty (120) days upon the Contractor's receipt of all required documents.
- The Contractor's failure to credential or re-credential Providers in a timely manner may result in corrective action, sanctions, fines and/or penalties as described in Sections G.3.6 and G.3.7.

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

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DELEGATED CREDENTIALING

- Some providers have succeeded in negotiating a “delegated credentialing” relationship (*i.e.,* the provider performs credentialing on behalf of the MCO, under MCO’s oversight).
- MCO saves costs; provider gains control over timing.
- Delegated credentialing typically requires provider to use national standards (*e.g.,* National Committee for Quality Assurance).

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LICENSURE – CONTRACT PROVISIONS

Notice

- MCO contracts typically require that a provider report any loss of licensure immediately to MCO.
- **Practice Pointer**. Avoid contract provisions that require notice whenever the provider or one of its clinician is in danger of losing license (i.e., nothing more than an allegation), as divulging information at that stage could be a liability risk.

Consequence

- In many contracts, the failure to maintain a licensure provides grounds for the MCO to immediately terminate the contract for cause.
- **Practice Pointer**. Revise provision so that loss of licensure by one clinician does not trigger immediate termination, so long as provider has continuing capacity to perform.

PAYMENT

DC MANAGED CARE CONTRACT REQUIREMENTS

C.5.36.2 - Claims Payment Capacity

- The Contractor shall have written policies and procedures for processing Claims submitted for payment from any source and shall monitor its compliance with these procedures. The procedures shall, at a minimum, specify timeframes for:
  - Submission of Claims;
  - Date stamping Claims when received;
  - Determining, within a specific number of days from receipt, whether a Claim is a Clean Claim or not;
  - Payment of Clean Claim in accordance with the Prompt Payment Act, D.C. Code § 31-3132;
  - Follow-up of pending Claims to obtain additional information;
  - Reaching a determination following receipt of additional information; and Payment of Claims following receipt of additional information.
- The Contractor shall accept Network and Non-Network Providers' initial Claim(s) for all services rendered within three hundred sixty-five (365) days from the date of service.

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

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DC MCO MODEL CONTRACT

C.5.36.3 - Timely Processing of Claims

- The Contractor shall pay or deny ninety percent (90%) of all Clean Claims within thirty (30) days of receipt, consistent with the Claims payment procedures described in § 1902(a)(37)(A) of the Act and D.C. Code § 31-3132.
- The Contractor shall adhere to these Claim payment procedures unless the Provider and Contractor agree, in writing, to an alternative payment schedule.
- If the Contractor fails to comply with this requirement, the Contractor shall be required to pay interest to Providers in accordance with D.C. Code § 31-3132(c).
- In accordance with 42 C.F.R. §§ 447.45 and 447.46, the Contractor shall pay ninety- nine percent (99%) of Clean Claims within ninety (90) days of receipt.
- The Contractor shall pay all other Claims within twelve (12) months of the date of receipt, except in the following circumstances:
  - This time limitation does not apply to retroactive adjustments paid to Providers who are reimbursed under a retrospective payment system, as defined in 42 C.F.R. § 447.272;
  - If a Claim for payment under Medicare has been filed in a timely manner, the Contractor may pay a Medicaid Claim relating to the same services within 6 months after the Contractor or the Provider receives notice of the disposition of the Medicare Claim;
- The date of receipt is the date Contractor receives the Claim, as indicated by its date stamp on the Claim, and the date of payment is the date of the check or other form of payment. The date of payment is the date of the check or other form of payment.

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

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CLAIMS SUBMISSION

MCOs typically require the submission of claims no more than 90 days after the date of service.

- Note that the District of Columbia requires Medicaid MCOs to accept claims from a provider for up to one year. (C.5.36.2.3 of the DC Medicaid MCO Contract).

Review the proposed contract for provisions concerning the consequences of **late claim submission.**

- Negotiate for a provision that makes MCO denial of late claims discretionary rather than mandatory.

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PROMPT PAYMENT

Just as MCOs have an interest in timely claims submission, providers have an interest in timely payment.

- **Practice Pointer**: Seek to have DC's prompt pay rules, including any automatic interest provisions for late payment, written directly into the provider agreement, so that a violation of the statute also results in a breach of contract.
- **Practice Pointer**: Seek to insert a right to receive a written explanation for all denied claims and the information that is needed by the MCO to process the claim for payment.

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PROMPT PAYMENT CONTRACTING TIPS

- **Prompt Payment.** Sample provision containing favorable language:

  Health Plan shall pay Provider for Covered Services in accordance with the rates set forth in Exhibit D within thirty (30) days of receipt of a Clean Claim in accordance with the Prompt Payment Act, D.C. Code § 31-3132, or such other time period required by applicable law/regulations or Government Contracts. In accordance with the Prompt Payment Act, D.C. Code § 31-3132, Health Plan agrees to provide written notice of the reason for any denied claims and pay Provider interest for any claims paid beyond thirty (30) days. The interest payable shall be at a monthly rate of:

  (1) One and one-half percent from the 31st day through the 60th day;

  (2) Two percent from the 61st day through the 120th day; and

  (3) Two and one-half percent after the 120th day

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PAYMENT RATES

- **Lesser of Charges or Fees**. MCO contracts routinely include provisions that permits them to pay less than required rates when a provider's charge for a service is less than the fee schedule rate.
- Be alert to unfavorable language such as the following:
  - Provider shall be paid for Provider Services rendered in accordance with the provisions set forth in Attachment A-1, or Provider's charges, whichever is less.
  - Payor shall reimburse Provider the lesser of billed charges or the rates of payment specified in Exhibit A hereto for Services provided to Members.
  - If Provider submits a claim for Medically Necessary Covered Services for an amount less than the applicable rate set forth in this Agreement, Provider will be paid the lesser of the billed amount or the rate set forth in this Agreement.
- **Practice Pointer:** Negotiate for the deletion of "lesser of" language so that MCO pays the fee schedule rate.

CORRECTION OF OVERPAYMENTS & UNDERPAYMENTS

MCO contracts typically allow the MCO to recoup **overpayments** (excess payment by the MCO to the provider)

- **Practice Pointer**. Negotiate language that imposes time limits on the MCO's **timeframe** for recouping overpayments from a provider.

Contracts commonly permit the MCO to recoup an overpayment by **offset;** the MCO subtracts the overpayment from any amounts due to the provider

- **Practice Pointer**. Negotiate language that requires the MCO to provide **notice** of the alleged overpayment (and afforded the provider an opportunity to **appeal** the determination) prior to offset.
- **Practice Pointer**. Negotiate language to permit the provider to dispute **underpayments** within a time frame that is equal to the time frame that an MCO may recoup overpayments.

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"ALL PRODUCTS" CLAUSES

MCOs typically reimburse providers at different rates for various lines of business (commercial/employer-based products, Medicare Advantage, Medicaid).

An "all-products" clause requires the provider to participate in all products (and rates) offered by the MCO (both current and future products).

Practice Pointer: Providers should have the ability to opt-out of any new products offered by the MCO.

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ALL PRODUCTS CLAUSES – REAL-LIFE CONTRACT PROVISIONS

- Be alert to unfavorable language such as the following all-products clause provisions:
  - Schedule 1.14 [related to product lines] may be amended by [Plan] from time to time to add or delete Programs.
  - Provider agrees to participate in provider networks of [Plan] made available to Payors for Members covered under benefit plans offered or administered by such Payors, including without limitation commercial plans, State Medicaid/government programs, and Medicare Advantage plans, in accordance with the terms and conditions of this Agreement.
  - [Plan] may amend this schedule to include additional Programs from time to time. Provider agrees that Provider will participate in all new Programs for which Provider is qualified as determined by [Plan].

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REGULATORY PENALTY PROVISIONS

Some contracts hold a provider liable for any fines or penalties assessed against the MCO by a state or federal regulatory agency that result from the provider's non-compliance with a requirement under the contract or provider manual.

- Under these provisions, a provider will be liable even if:
  - MCO was unaware of the non-compliance, took no steps to monitor the provider, or correct the provider's non-compliance.
  - Provider did not act negligently but made good faith efforts to comply.
- Providers do not have authority to appeal or dispute the regulatory agency's fines or penalties against the MCO.
- **Practice Pointer**. Remove language that results in incurring liability for fines or penalties assessed against the MCO or, alternatively, add language that requires the MCO to notify provider of the assessment of such fines or penalties and grants right to provider to appeal or dispute agency's fines or penalties against the MCO.

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GENERAL TERMS

CONTRACT TERM

Contracts generally state how long the contract will be in force (**term**) and the procedures for renewing or terminating the contract.

When initially contracting with an MCO, the provider may want to limit the term of the contract to one year without automatic renewal ("evergreen") provisions.

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TERMINATION

Contracts can typically be terminated **"for cause"** or **"without cause."**

The situations that constitute cause will be listed in the contract, *e.g.,* breaches of material terms of the contract.

Sometimes a party may terminate without cause after providing notice to the other party.

Recognize that when contracts may be terminated without cause, ***the notice period*** becomes the effective term of the contract.

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TERMINATION

Practice Pointers

- Consider adding language so that provider has similar rights to terminate the contract for cause, including but not limited to, in the event that an MCO loses its license to operate or enters bankruptcy proceedings.
- Consider adding language to permit either party to terminate the contract without cause.

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CONTRACT AMENDMENTS

Amendment Types

- **Unilateral amendment by the MCO:** Should not be permitted unless contract is being amended to comply with regulatory or statutory changes.
  - **Practice Pointer.** Provider should have right to request specific regulatory or statutory basis for the proposed change.
- **Auto-amendment by the MCO:** Does not require provider's signature but takes effect if provider does not object to change within given time period.
  - **Practice Pointer.** Objection to proposed amendment should prevent the amendment from taking effect; objection to the amendment should not require provider to terminate contract to avoid its effect.
- **Written amendment:** Requires the written consent of both parties. Always safe!

AMENDMENTS

Scope

- Amendment provisions are particularly crucial in MCO contracts because the clinical, operational, and financial environments in which the parties operate are subject to constant change.
- Distinguish between modifications that apply solely to the contract itself, including “program attachments” and “payment exhibits”, and those modifications that apply to the MCO’s policies and procedures, including the MCO provider manual.

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AMENDMENT – REAL-LIFE CONTRACT PROVISIONS

- **Unilateral Amendment.** These provisions allow a plan to amend the contract unilaterally for any reason, not solely for regulatory or statutory changes.
  - [MCO] may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required.
  - Except as otherwise provided for in this Agreement, [MCO] retains the right to amend this Agreement, any attachments or addenda by making a good faith effort to provide notice to Provider at least thirty (30) days in advance of the effective date of the amendment.
- **Auto-Amendments.** These provisions suggest that the provider can opt-out of amendments it finds objectionable, but in reality, force the provider to terminate the entire agreement if it objects to a proposed amendment.
  - Except to the extent that [MCO] determines an amendment is necessary to effectuate Regulatory Requirements, if Provider objects to the amendment, then Provider has the right to terminate this Agreement, and such termination shall take effect on the later of the amendment effective date identified by [MCO] or one hundred eighty (180) days from the date Provider has provided notice of its intention to terminate the Agreement pursuant to this section. Failure of Provider to provide such notice to [MCO] within the time frames described herein will constitute acceptance of the amendment by Provider.

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NOTICE

The notice clause describes how communications must be made by the parties under the contract to have legal effect.

Notice clauses typically describe the:

- Means of communication, *e.g.,* written or electronic, provider bulletin, or website.
- Mode of delivery, *e.g.,* courier service, certified postal service, electronic delivery.
- Name of recipient (or recipients) and their address.

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NOTICE – PRACTICE POINTERS

Contracting Pointers.

- Confirm that the notice clause contains the correct name and title of the individual(s) at the provider who should receive official notices under the contract.
  - You can always add additional names/addresses!
- Consider adding electronic notice provisions if not already included in the provision.
- Do not rely on the address information for the provider contained in the MCO's files, as it could be inaccurate.
- If notice to the MCO refers to an address in the provider manual, add an address in the event that there is not an address in the provider manual for the type of notice required under the contract.

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NOTICE – REAL-LIFE CONTRACT PROVISIONS

- Be alert to unfavorable language such as the following:
  - Any notice given under this Agreement to [Plan] shall be sent in writing by certified mail, return receipt requested, postage prepaid, or by overnight courier service, with a copy to General Counsel, at [Plan], Attn: Senior Vice President.
  - Any notice given under this Agreement to Provider shall be in writing and sent: (i) by overnight carrier, (ii) by posting on the [Plan] website, (iii) electronically to a designated contact at an agreed upon e-mail address; or (iv) by regular or certified mail, return receipt requested at the address set forth at the beginning of this Agreement.
  - Notice shall be effective in the case of (i) overnight courier service, on the next business day after the notice is sent; (ii) regular or certified mail, three business (3) days after the letter is deposited, postage prepaid, in a United States post office depository; and (iii) upon posting on the [Plan] website or sent electronically.

INDEMNIFICATION

Indemnification provisions state which party to a contract bears the risk (and liability) for certain events or acts of third parties.

- A party is "indemnified" if, by virtue of a contract provision, it avoids assuming responsibility for another party's acts or omissions arising out of performance of the contract.
- **Practice Pointer.** Indemnification clauses should apply to both parties.

INDEMNIFICATION

The contract should allocate responsibility:

- To the **MCO** for coverage decisions, selection of providers, utilization management activities, compliance with state and federal insurance laws, and other acts within its control.
- To the **provider** for professional medical judgment (including malpractice claims), medical record documentation requirements, accurate claims submission, and other acts within the provider's control.

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DISPUTE RESOLUTION PROCESS

The contract should contain a streamlined, expedited process for **claims disputes**, and a more elaborate process for other disputes

The contract should use a **graduated, step-by-step** dispute resolution process

Practice Pointers. Avoid obligation to seek dispute resolution within a short (one-year) period

- Informal negotiation
- Mediation
- Arbitration (which should be binding) or judicial remedies

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QUESTIONS / COMMENTS/ IDEAS

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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:

- **Where Quality Meets Legal**
  (Aug. 30, 1 – 2 pm ET)
- **Key Considerations for Value Based Payment Arrangements**
  (Sept. 19, 12 – 1 pm ET)

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HMA

HEALTH MANAGEMENT ASSOCIATES

Adam Falcone, JD, MPH
Subject Matter Expert
AFalcone@feldesmantucker.com
Link to Bio

Michele Melden, JD
Subject Matter Expert
mmelden@healthmanagement.com
Link to Bio

Caitlin Thomas-Henkel, MSW
Project Director
cthomashenkel@healthmanagement.com
Link to Bio

Amanda White Kanaley, MS
Project Manager
akanaley@healthmanagement.com
Link to Bio

Samantha Di Paola, MHA, PMP
Project Coordinator
sdipaola@healthmanagement.com
Link to Bio