

Medicare Advantage: Contract Negotiation Tips



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Melinda A. Gaboury, with more than 30 years in home care, has over 20 years of executive speaking and educating experience, including extensive day to day interaction with home care and hospice professionals. She routinely conducts Home Care and Hospice Reimbursement Workshops and speaks at state association meetings throughout the country. Melinda has profound experience in Medicare PDGM training, billing, collections, case-mix calculations, chart reviews and due diligence. UPIC, RA, ADR & TPE appeals with all Medicare MACs have become the forefront of Melinda's current impact on the industry. She is currently serving as Chair of the NAHC/HHFMA Advisory Board and Work Group and is serving on the board of the Home Care Association of Florida and the Tennessee Association for Home Care. Melinda is also the author of the Home Health OASIS Guide to OASIS-E and Home Health Billing Answers, 2024.

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Regina Wild, LPN Director of Managed Care Consulting Services

Regina Wild is currently Director of Managed Care Consulting with Healthcare Provider Solutions. Regina is an experienced healthcare professional with over 15 years of industry experience. She has worked as a nurse, business development professional, and contracting/credentialing specialist. Regina has a deep understanding of the healthcare system and has worked in various healthcare settings, gaining valuable insights into the industry. Regina's primary focus is on Managed Care contracting, where she helps providers maximize reimbursement, strengthen referral relationships, and expand their market presence. She is passionate about assisting healthcare providers in navigating the complexities of the industry and achieving their goals. In addition to her work in the healthcare industry, Regina is actively involved in several healthcare associations. She serves on education and reimbursement committees and is a sought-after speaker at conferences. Regina's expertise and dedication to the field make her an asset to any healthcare organization.



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Navigating Medicare Advantage Contracting

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What we will discuss today

What is Medicare Advantage

Different managed care products

Why Accept Medicare advantage plans

Where do you start?

Tips for negotiations

Handling closed markets

Steps to consider after you obtain contracts

Keys to renegotiating current contracts

Best Practices



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What is Medicare Advantage

Also known as Part C or MA Plans

They provide Medicare part A & B = C and often include Part D

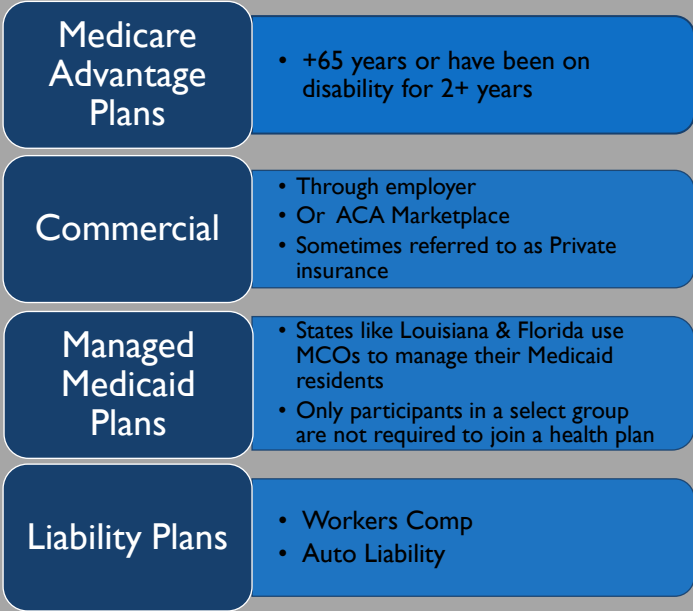
Offered by private companies that are awarded contracts from CMS

Payers bid and receive rebates, which is how they can offer extra benefits



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Managed Care Products



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Different types of Plans



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Why Accept Medicare Advantage



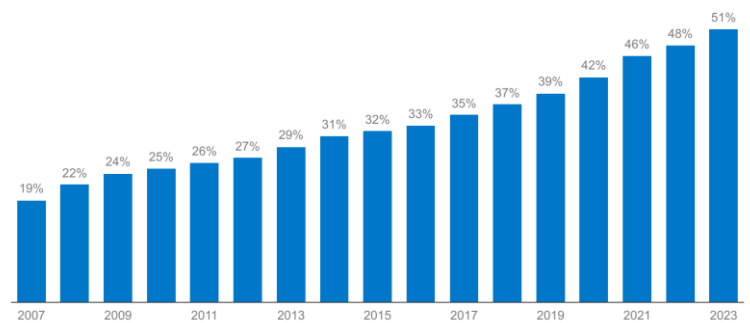
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51% of beneficiaries enrolled in a Medicare Advantage plans

Over 31 million enrolled

>2% increase year over year

Figure 1
Total Medicare Advantage Enrollment, 2007-2023



NOTE: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.0 million people are enrolled in Medicare Parts A and B in 2023.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023.

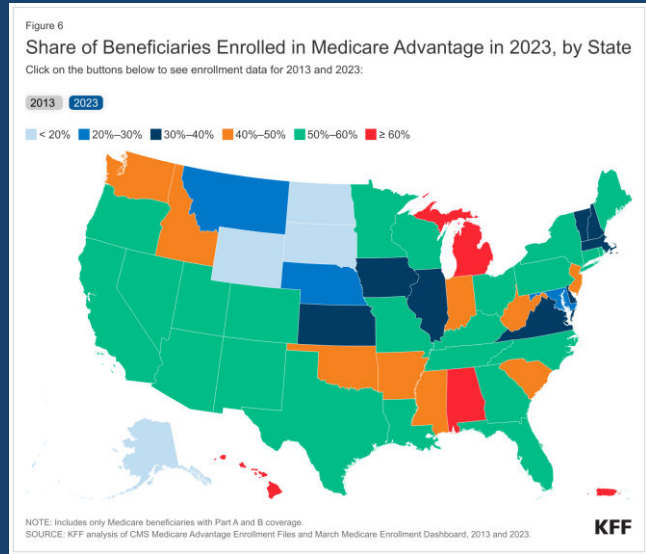
KFF



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Share of Beneficiaries enrolled by State

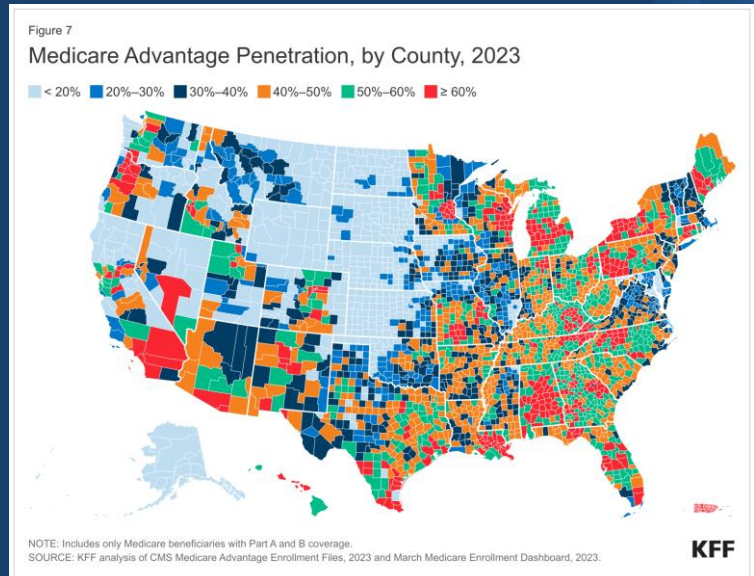
- Florida 58%
- Louisiana 56%
- California 55%
- Alaska only 2%



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Penetration by County

- St. Charles, LA 76%
- Cameron, LA 23%
- Miami-Dade, FL 79%
- Monroe, FL 20%
- Northern California very low
- Los Angeles County 55%
- Sullivan, TN 70%



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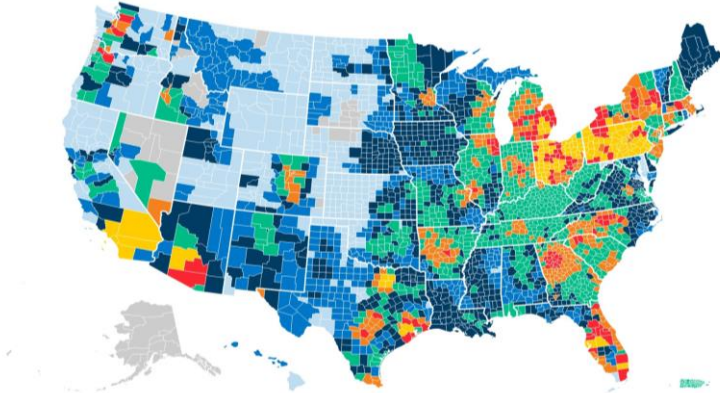
Figure 5

One-third of Medicare beneficiaries (in 8 percent of counties) have more than 50 Medicare Advantage plans available where they live in 2024

Click on the buttons below to see number of Medicare Advantage plans across years:

2019 2024

0 plans (68 counties) 1-10 plans (342 counties) 11-20 plans (507 counties) 21-30 plans (783 counties) 31-40 plans (893 counties) 41-50 plans (369 counties) 51-60 plans (136 counties) 61 or more plans (125 counties)



NOTE: Excludes SNPs, EGHPs, HCPPs, PACE plans, cost plans, and MMPs.
SOURCE: KFF analysis of CMS Landscape files for 2024.

KFF



Many plans
to choose
from in
2024

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Where do you
start?

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Identify Payers in Market



CMS Data

Medicaid enrollment data

Review denied referrals

Talk to your referral sources

Open Enrollment



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Sample CMS DATA Hillsborough, FL

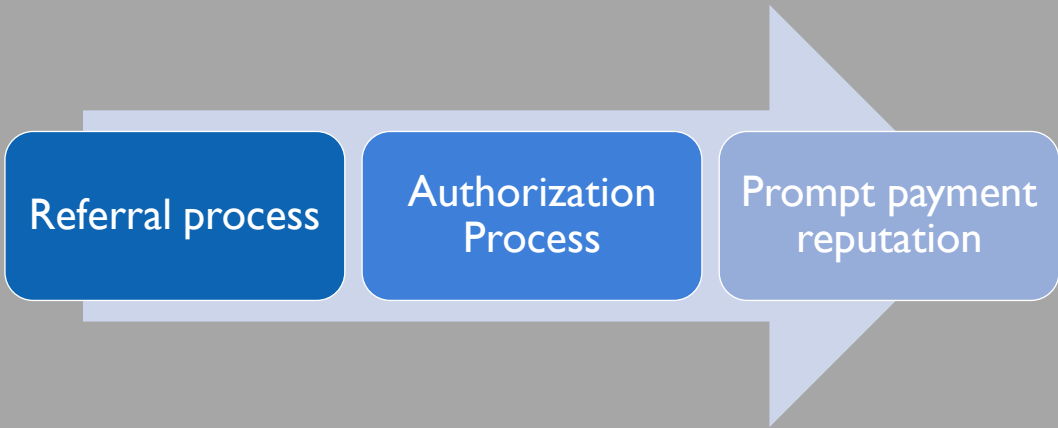
[MA Enrollment by SCC 2024 01 | CMS](#)

HUMANA MEDICAL PLAN, INC.	HMO/HMOPOS	34767
PREFERRED CARE PARTNERS, INC.	HMO/HMOPOS	17375
OPTIMUM HEALTHCARE, INC.	HMO/HMOPOS	14083
CAREPLUS HEALTH PLANS, INC.	HMO/HMOPOS	13329
CARE IMPROVEMENT PLUS SOUTH-CENTRAL INSURANCE CO.	Local PPO	10106
AETNA LIFE INSURANCE COMPANY	Local PPO	9802
HUMANA INSURANCE COMPANY	Local PPO	9710
CARE IMPROVEMENT PLUS SOUTH-CENTRAL INSURANCE CO.	Local PPO	7292
AETNA HEALTH INC. (FL)	HMO/HMOPOS	5865
Sunshine State Health Plan, Inc.	HMO/HMOPOS	5466
AETNA LIFE INSURANCE COMPANY	Local PPO	5025
FLORIDA BLUE MEDICARE, INC.	HMO/HMOPOS	4183
DEVOTED HEALTH PLAN OF FLORIDA, INC.	HMO/HMOPOS	3616
SIMPLY HEALTHCARE PLANS, INC.	HMO/HMOPOS	3544
SIERRA HEALTH AND LIFE INSURANCE COMPANY, INC.	Local PPO	3338
BLUE CROSS AND BLUE SHIELD OF FLORIDA, INC.	Local PPO	2462
BAYCARE SELECT HEALTH PLANS, INC.	HMO/HMOPOS	2202
CARE IMPROVEMENT PLUS SOUTH-CENTRAL INSURANCE CO.	Regional PPO	1986



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Items to Consider








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HMO vs PPO

HMO- HEALTH MAINTENANCE ORGANIZATION

-  Health plan requires PCP to coordinate care
- Require pre-cert or prior authorization 
-  Reimbursement model often FFS
- Smaller networks 
-  Member has lower cost

PPO-PREFERRED PROVIDER ORGANIZATION

-  Members not required to select PCP
- Sometimes prior auth/authorization not required 
-  Often out of network providers are reimbursed PDGM
- Members often have a higher up-front cost if using an OON provider 
-  Depending on market there may be fewer PPO members



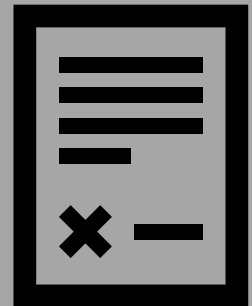
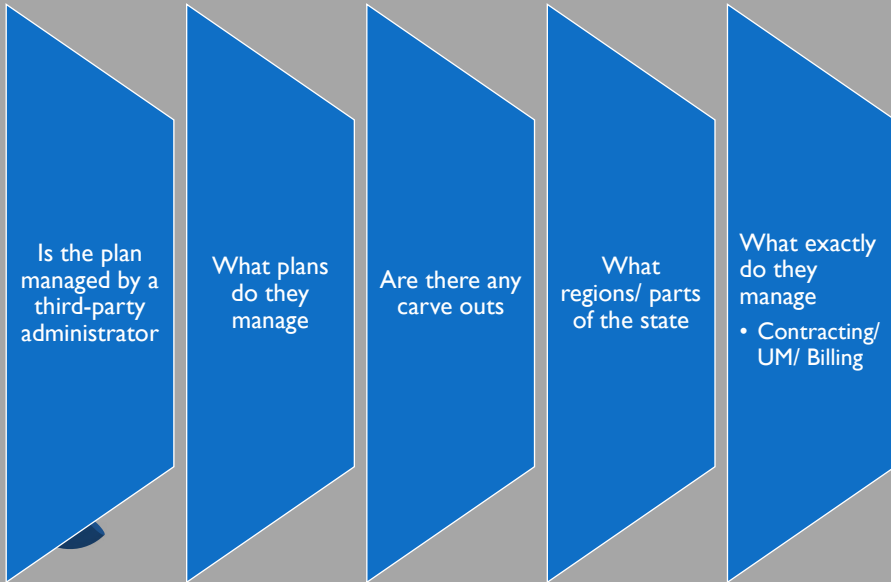
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Where to Next?



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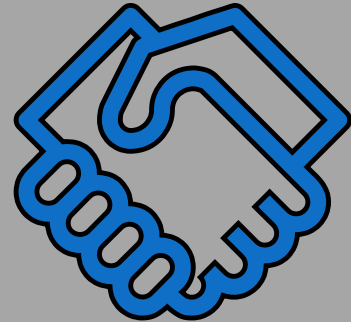
New Contracts



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New Contracts

- **What do they request first?**
 - Letter of interest
 - Credentialing paperwork
- **Credentialing**
 - Make sure paperwork is complete
 - No Expired documents or due to expire in 60/90 days
- **Confirm Receipt**
- **Establish turn around time & what to expect next**
- **Contracting team & Credentialing team are different**
 - Request contact information



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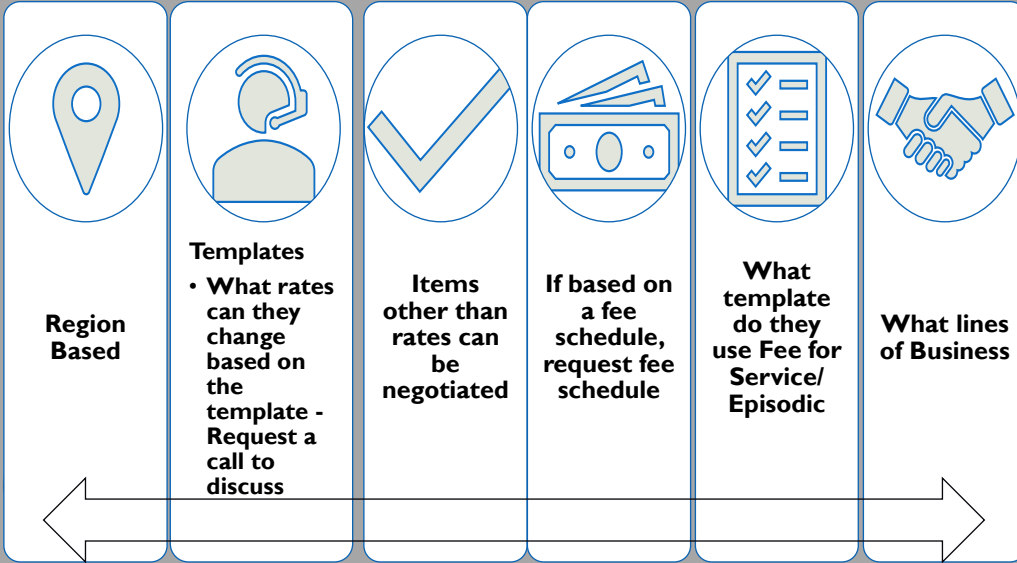
Most common Credentialing Items

- Agency License
- Current W-9
- Accreditation if applicable
- Proof of Medicare/ Pecos report
- Proof of Medicaid- If applicable
- CLIA
- Workers Comp COI- if applicable
- List of licensed staff with number
- General Liability/ Professional Liability COI
 - 1million/ 3million



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Agreement/ Proposal



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Star Ratings



Some plans require a specific star rating



Some will do a clinical review if no star rating



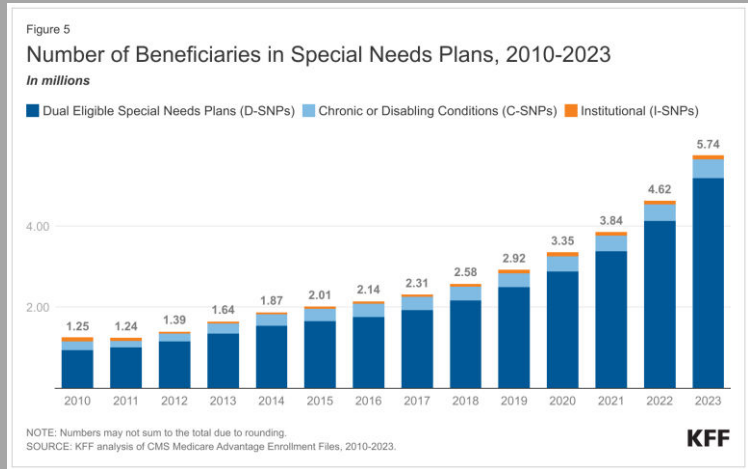
When your star rating improves circle back



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Medicaid

- Some plans that offer DSNP plans will not contract with providers that do not have a Medicaid number
- Some plans will extend the Medicare Advantage Plans if you also contract with the Medicaid Line of business
- You do not have to accept MMA or LTC referrals just because you have a Medicaid number

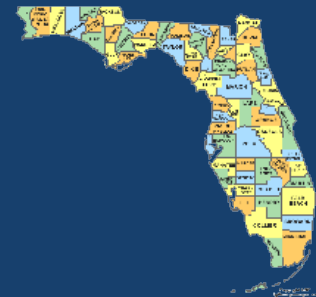
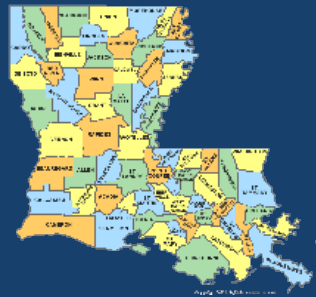


Service Areas

Where are you licensed?

Where is your current reach?

Determine network need



Closed Markets

Can you cater to a Special Needs Plan?

- Cardiac
- Pulmonary
- Kidney

Do you successfully utilize telehealth?

Any unique certifications or training?

What do you offer that others do not?



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Closed Markets

- Track referrals
 - How accurate is your CRM?
- Are you accepting PPO referrals from the payer
- Referral partners- are they having trouble placing
- When do they recommend that you follow up



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Contracts – Now What?

-  Fully executed copies
-  Confirm contract load!
-  Confirm all lines of business are loaded
-  Provider number
-  Attend Provider training
-  Who is your contact now that contract is complete
-  Provider Manual trumps the contract
-  Get to know the portals



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Renegotiating



- Gather facts
 - How old is your contract
 - Contract effective date
 - Start of Care Vs Denials
- Lines of business
- Service areas
- Letters of recommendation
- Create a clear proposal
- Find out what process looks like/ who is involved
- Ask for reasonable time to follow up

If you don't ask, the answer will always be no



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Best Practices

- Be organized
- Be tenacious
- Be consistent
- Professional
- Pick up the phone
- Always counter-offer
- Make your requests clear and in writing
- FOLLOW UP, FOLLOW UP, FOLLOW UP



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Have any questions?

Scan the QR Code to
schedule a call!

***Thank You for
Participating!***

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