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BASICS OF MANAGED LONG TERM CARE CONTRACTING

LeadingAge New York

Jewish Home Lifecare

New York, New York

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Brian T. McGovern, Esq.
Stephanie Marcantonio, Esq.
Cadwalader, Wickersham & Taft LLP
One World Financial Center
New York, New York 10281
(212) 504-6000

Overview

I. Benefits of Contracting with MCOs

II. Preparing for Negotiations

   A. Internal Diligence

   B. Threshold Questions

III. Reviewing the Contract

IV. Group Negotiations & Antitrust Considerations

Benefits of Contracting with MCOs

I. Continued (current LTHHCPs, CHHAs, and ADHCs) and Future (Nursing Home) Viability as a Provider of Long Term Care Services

II. Increased Patient Referrals

III. Opportunity to Negotiate

IV. Participation in MCO's network

V. Retention of current patients who enroll in MCO's plan

VI. Electronic Claims Payment/Cash Flow

Benefits of Contracting with MCOs

Financial Protections

A. **Presumed Security of a Fiscally Sound Payor -- HMOs and Prepaid Health Services Plans are required to meet specified fiscal reserves; undergo character and competence review.**

B. **Presumed Timely Payment -- Prompt Payment Law (Insurance Law § 3224-a): Claims must be --**

1. **Paid within 45 days if submitted on paper**
2. **Paid within 30 days if submitted electronically**
3. **Denied within 30 days, or**
4. **Written request for additional information within 30 days of receipt of claim. Must request ALL necessary information.**
5. **Interest begins to accrue on the day the claim payment is due.**
6. **Each late claim is a separate violation. Can be fined by Insurance Department.**

Internal Diligence

A. Providers must have a firm understanding of their cost to deliver care in order to determine if the rates being offered by the MCO are acceptable.

B. Assess the provider's strengths & weaknesses and its goals in contracting with MCO.

1. Provider Affiliations.
2. Clinical Operations.
3. Staffing.
4. Management Information Systems.
5. Physical Plant Issues.
6. JCAHO Accreditation.
7. Survey Performance.
8. Compliance Record.

Internal Diligence

C. Identify the scope of services the provider wishes to offer to the MCO. Examples of services, in addition to nursing facility services, that can be offered include:
   1. Wound care
   2. Respiratory therapy
   3. Alzheimer's care
   4. Fractures
   5. Skin ulcers
   6. Rehabilitation

D. Identify Bargaining Priorities & "Deal Breakers".

Threshold Questions

Is this the right MCO?

I. What is the MCO's reputation? How long has it been in business? Is it solvent?

II. Sources of Information:

- **The New York State Managed Care Plan Performance Report;**
- **Insurance Department Reports on Examination;**
- **Freedom of Information Law/Act Requests to the Department of Insurance and CMS;**
- **Annual Reports;**
- **Reference Checks;**
- **Copies of Medicare Risk/Cost Contracts with CMS and/or Medicaid Contracts with the Department of Health;**
- **Accreditation Materials.**

III. How many lives are covered by the MCO -- What is the percentage of "commercial" lives vs. Medicare and Medicaid covered lives? How many of the covered lives are eligible for your services?

Threshold Questions

I. Identify the MCO benefit package for long term care and ancillary services being furnished by the provider.

II. Obtain copies of MCO enrollee and provider materials.

III. Are there any enhancements to the Medicare benefit offered by the MCO that make it more attractive to enrollees?

Negotiation Constraints

I. Form Contract

   A. MCOs will have a standard form of contract.

   B. Most MCOs are willing to amend their form contract (to an extent).

      1. Letter Agreement, Addendums, Amendments.

II. Required Provisions

   A. Compliance with 10 NYCRR Subpart 98-1, all other applicable laws and regulations, and the New York State Department of Health Provider Contract Guidelines for MCOs and IPAs.

Required Provisions

I. Generally State-mandated provisions will be in an appendix to the MCO's form contract denoting the New York State Standard Clauses.

II. The "Standard Clauses" take precedent over inconsistencies in other provisions of the contract, unless the contract exceeds the minimum requirements of the Standard Clauses.

III. Will include "hold harmless" language prohibiting the provider from billing enrollees or the Department of Health.

Reviewing the Contract

I. Review the contract with the following in mind:

A. Know what you are agreeing to. If you do not understand a contract provision, ask for it to be explained.

B. Obtain and review copies of all referenced documents, procedures and policies prior to execution. If they are referenced, they are likely part of the contract – the provider is agreeing to abide by the terms of such documents and failure to do so may be a breach of the MCO agreement.

C. Require prior written notice of any changes to policies and procedures incorporated by reference.

D. Seek to limit administrative obligations which are not material to the contract, and where the failure to perform would be a breach of the agreement.

Reviewing the Contract

I. Basic provisions of a contract
   - A. Parties
   - B. Execution and Effective Dates
   - C. Recitals
   - D. Services to be provided
   - E. Compensation
   - F. Duration and Termination
   - G. Warranties and Representations
   - H. Indemnification
   - I. Notices and Modifications

Reviewing the Contract

Parties to the Contract

A. **Identify the contracting entity: Always make sure and/or have the MCO represent that the corporate entity with which you intend to contract is an active and valid legal entity and that the person signing the agreement has the authority to bind the entity.**

B. **Is it a single MCO or a "Network" of MCOs? Problems created by ambiguous "Entity" descriptions include:**

   1. **Who has the authority to bind the MCO and the other entities described in the contract?**
   2. **Whose policies and procedures does the provider follow?**
   3. **Who is accountable for payment?**

Reviewing the Contract

Date

A. This Agreement is dated as of the ___ day of _____. OR

B. This Agreement, executed this ___ day of _____, is effective as of the ___ day of _____.

C. If services are already being provided to enrollees, make sure the effective date is retroactive to the first date of service.

Recitals

A. WHEREAS, Party X desires Party Y to provide skilled nursing services ("Services") to the enrollees of Party X; and.

WHEREAS, both parties have agreed to the terms and conditions upon which Party Y shall perform such Services.

NOW, THEREFORE, in consideration of the mutual promises, it is understood and agreed to by the parties as follows:

Managed Care Contracting Issues

Services to be Provided

A. "Covered Services" are the benefits offered by the MCO to its enrollees.

B. Make certain the definition of "Covered Services" accurately reflects the services to be provided by the provider for the negotiated rates.

   1. Does the "Covered Services" list include exactly what the provider is authorized to and undertaking to provide?

   2. How will the provider be notified of changes to the MCO benefit package that affect the "Covered Services"? Does the provider have the right to opt-out of the agreement if any changes are unacceptable?

Managed Care Contracting Issues

How are Medical Necessity and Emergency Care Determinations Made?

A. **"Medical Necessity" and "Emergency" -- How are those terms defined?**

B. **Who makes the determinations? If the provider is not permitted to make medical necessity determinations for services provided under its roof, how long will it take to obtain the determination from the MCO?**

C. **What are the provider's "due process rights" in the event of a dispute with the MCO?**

D. **The provider should retain the right to control admission, transfer and discharge decisions.**

Managed Care Contracting Issues

Authorizations/Referrals For Covered Services.

A. **Who will make referrals to the provider?**

B. **Is it required that the MCO provide authorization for the referral?**

C. **How long will it take to obtain the authorization?**

D. **How will authorizations be documented?**

E. **Will authorization cover the entire admission?**

F. **No prior authorization should be required to respond to "emergency."**

Dispute Resolution

Contract should clearly describe the dispute resolution process.

A. **What are the provider's appeal rights? What are the levels of internal and external appeals?**

B. **How are overpayments and underpayments handled?**

C. **What are the provider's obligations for complying with the MCO's administrative procedures?**

D. **Do any of the MCO's grievance/appeal procedures conflict with the provider's obligations under Department of Health regulations?**

Dispute Resolution

External Appeal Process Dictated by § 4914 of the Public Health Law for Article 44 MCOs

A. Review by neutral medical professional for denials based on lack of medical necessity.

B. Must exhaust internal appeal after initial denial.

C. Must file external appeal application within 45 days of final adverse determination.

D. Providers can appeal retrospective and concurrent denials.

Managed Care Contracting Issues

Pricing Terms

A. What is included/what is excluded? Will some services be carved out of the rate? Will the provider need to purchase stop-loss insurance or another form of reinsurance?

B. Identify any ambiguity in rate structures.

C. Who makes the determination of which rate applies when there is a multi-tiered rate structure?

D. What other ancillary services will be bundled with the provider's basic services?

E. How will rate changes be handled? Under what circumstances will adjustments be made?

F. How will bed-holds be addressed?

Managed Care Contracting Issues

Financial Risk

A. What are the provider's obligations to enrollees upon exhaustion of the MCO benefit?

B. What steps can be taken to protect the provider from financial loss?

C. What are the enrollee's financial obligations for care furnished at the provider and do those obligations impact an enrollee's incentive to seek services?

D. Identify what is to happen in the event of the MCO's bankruptcy.

Risk Sharing

I. 10 NYCRR § 98-1.2(kk) defines risk sharing as the contractual assumption of liability by a provider for the delivery of health care services to enrollees of an MCO.

II. Risks to Provider

   A. The financial risk that the cost of the services required by the patient will exceed the payment received by the MCO and/or the provider.

   B. The potential increase in liability arising from a provider's delivery of services in accordance with "guidelines" prescribed by an MCO.

III. Insurance Department (now Department of Financial Services) must approve the arrangement.

Risk Sharing

IV. Financial Review Criteria

A. Level 1: Contract with a provider based on FFS, including withholds or bonuses up to 25% of the payment to the provider: No financial review by DOI.

B. Level 2: Contract that transfers risk to a provider for a single service directly provided. No financial review.

C. Level 3: Contract that transfers risk to provider for multiple services provided directly, withholds or bonuses greater than 25%. If provider's net worth is more than 0, no security deposit. If equal to or less than 0, security deposit must be established of 12.5% of the estimated annual medical costs for the services covered under the agreement.

Billing and Payment

I. Billing And Payment Terms.

- A. What are the MCO's billing requirements?
  - 1. Billing format.
- B. Encounter and utilization data reporting obligations.
- C. How often or on what cycle will the MCO pay?
- D. What happens in the event of a late payment?
- E. Will MCO pay on "receipt" or "verification" of a bill?
- F. Under what circumstances will MCO correct payments?
- G. Will the provider be responsible for collection of coinsurance/copayment amounts? How will the provider be notified of the MCO enrollee's out-of-pocket maximum and of changes to these amounts?

Billing and Payment

II. Timely filing of Claims

A. Contract may provide more time but generally deadline cannot be less than 120 days after the date of service.

B. Medicaid Managed Care claims deadline may not be less than 90 days. You can push for more time to file claims. Consider current practice and what is realistically achievable.

III. Late Filing

A. Under New York State Insurance Law § 3224-a(h)(2), a claim denied solely for being untimely must still be paid if the provider can demonstrate that the late filing was the result of an unusual occurrence, and the provider has a pattern or practice of timely filing.

B. The MCO may impose a 25% penalty.

C. Not applicable to claims submitted over 365 days after the date of service.

Managed Care Contracting Issues

Identify the interrelationship between the provider and other MCO participating providers.

A. **Will the provider be required to use MCO participating providers for such ancillary services as transportation or laboratory services? Do any of the provider's agreements prohibit the use of other non-participating providers?**

B. **What prices will be charged if the provider wishes to use MCO participating providers?**

C. **Will provider physicians be included on MCO's panel? Will the provider be required to give privileges to MCO participating physicians? Will non-MCO point of service physicians be allowed to follow their patients at the provider?**

Managed Care Contracting Issues

MCO Obligations.

A. **Should educate its enrollees about MCO benefits, coverage issues and about the services offered by participating providers.**

B. **Should notify members when services sought are "non-covered" and of their personal responsibility for paying the provider for such services.**

C. **Should share utilization data with the provider.**

D. **Should actively market in the provider's area; all of its marketing materials referencing the provider should be pre-approved by the provider and describe the provider's services accurately.**

Duration and Termination

I. The contract should state explicitly the date or event that will serve as the starting point of the contract. Again, if services are already being provided to enrollees, effective date should be retroactive.

II. The parties should state the date or event that will mark the end of the contract term or the deadline for performance.

   A. "For cause" vs. "without cause" termination clauses.

III. The contract should state whether the parties will have a right to renew or extend the term of the contract, and the procedures that must be followed to obtain a renewal or extension.

IV. Termination or non-renewal of an agreement with an MCO which serves 5% or more of an enrolled population in a County will require the approval of DOH.

V. Responsibility and payment for post-termination care.

Indemnification and Insurance

Insurance and Indemnification

A. The MCO should indemnify the provider against any loss or expense arising out of (i) the MCO's negligent acts or omissions, (ii) MCO's breach of its obligations pursuant to the Agreement, or (iii) any violation of law by the MCO.

B. MCO will likely agree to indemnify, but ask that it be mutual or reciprocal.

C. Where there is an indemnification, there should be a corresponding insurance provision.

D. The provider's insurance carrier should review and approve all insurance and indemnification clauses applicable to the provider.

Notice Provisions

Review the notice provisions for accuracy

A. Specify matters that require one party to give notice to another party.

B. State expressly the address office where the notice must be delivered and the manner in which it is to be delivered.

C. State the timing of delivery of such notice, and effective date of proposed change.

D. State whether effectiveness of notice requires actual receipt or merely transmittal or placement with the specified carrier.

E. State expressly whether such notice must be in writing or may be given orally. (Recommend writing)

F. State that a party give notice of the change in the manner that the contract otherwise provides for giving of notices.

Assignability

I. A contracts to provide health care services for the enrollees of B. If B assigns the contract to C, then B is the assignor and C is the assignee. C is then obligated to pay A for the services. B no longer has an obligation to pay A for health care services provided to enrollees. Raises all the same initial financial risks.

II. Permitting assignment

   A. The contract should indicate whether there are restrictions on any party's assignment rights.

   B. The contract should specify whether the rights are the same for both parties, and if not, how they differ.

Assignability

III. Permitting assignment

A. At a minimum, the assignor should be required to (a) notify the non-assigning party of the assignment, (b) identify the assignee, and (c) provide the non-assigning party with written confirmation that the assignee acknowledges receiving a copy of the contract and consents to be bound by all of its terms and conditions. We suggest that the providers consent be required for assignment by the managed care organization.

B. The clause should, if desirable, provide a way out of the relationship as an alternative to forcing someone to remain, involuntarily, party to the contract.

Waivers to Beware of

I. Punitive damages

II. Defenses that may be raised

III. Trial by jury

IV. Attorney's fees and legal costs

Arbitration Clause

I. Generally, an arbitration clause provides that any dispute, controversy or claim arising out of or in connection with the agreement, or the breach, termination or invalidity thereof, shall be referred to arbitration in accordance with the American Arbitration Association rules in force at the time of the dispute.

II. A contract with an MCO must state that DOH is not bound by arbitration or mediation decisions; that the arbitration will take place in NY and that the Commissioner will be given notice of all issues going to arbitration or mediation and copies of all decisions.

Choice of Law Provisions

I. Typically, the clause will simply say, “All disputes arising out of this contract shall be determined in accordance with the laws of the State of New York without reference to choice of law provisions.”

Antitrust Concerns

Prohibited Activities

I. Per se offenses are those which courts have determined to be illegal on their face without further inquiry into the effect of the particular restraint on competition.

- **A. Examples of per se violations of Section 1 of the Sherman Act include:**
  1. **Price fixing agreements.**
  2. **Agreement among competitors to exchange price information.**
  3. **Market and customer allocations by competitors.**
  4. **Group boycotts and concerted refusals to deal by competitors.**
  5. **Certain tying arrangements.**
- **B. Rule of Reason Analysis**
  1. **Conduct that is not per se illegal is subject to the rule of reason and evaluated based on the market share of the parties and the pro-competitive and anti-competitive effects resulting or likely to result from the conduct.**

Antitrust Concerns

I. "Exclusivity" clauses, whereby a provider must agree not to contract with any other MCO or IPA while not per se illegal, are not viewed favorably by DOH; limit enrollee access and provider choices.

II. "Exclusion" clauses, whereby a provider must agree not to accept enrollees of one or more specified MCOs, are not viewed favorably by DOH; limit enrollee access and provider choices.

III. "Most Favored Nation" clauses, whereby a plan may unilaterally reduce its negotiated rate where a competing plan has negotiated lower rate with the provider; not per se illegal, discouraged by DOH and unlikely to survive a rule of reason analysis.

Negotiating Group: Not Permitted

U.S. Dep't of Justice v. Classic Care Network (E.D.N.Y. 1995)

I. Factual Background

A. Classic Care Network Inc. ("Classic Care") is a N.Y. not-for-profit corporation whose principal place of business is Nassau County. Classic Care's 8 member hospitals are located in Nassau and Suffolk counties. Most of the member hospitals directly competed in the outpatient and inpatient medical services markets on Long Island.

B. In forming Classic Care, the member hospitals signed a memorandum of understanding pursuant to which each hospital agreed that:

1. No member would enter into any contract with an HMO or MCO without the collective approval of all members of Classic Care;
2. Classic Care would be the exclusive bargaining agent for the member hospitals with respect to negotiations with HMOs and MCOs;
3. Member hospitals would offer no discounts on inpatient rates and only a ten percent (10%) discount on outpatient rates to HMOs and MCOs;
4. Member hospitals agreed to refrain from contracting with HMOs who sought to convert DRG rates on inpatient hospital services to per diem rates; and
5. Member hospitals agreed on the terms and conditions upon which any most-favored nation clauses proposed by a third payor would be accepted.

Negotiating Group: Not Permitted

II. Violations

A. The member hospitals were charged with engaging in a continuing combination and conspiracy in unreasonable restraint of interstate trade and commerce in violation of Section 1 of the Sherman Act. The essence of the conspiracy was an agreement by the member hospitals to form a joint sales agency to coordinate contracting with HMOs, the purpose and effect of which was to prevent or limit discounts on inpatient and outpatient rates.

Negotiating Group: Not Permitted

III. **Penalties**

A. Each hospital was enjoined from:

1. Directly or indirectly entering into any agreement with any hospital in the Long Island area concerning:

   i. negotiation, selection, approval, acceptance or refusal of any contract with any third party payor for the delivery of hospital services;

   ii. the terms or amounts of any fee to any third party payor; or

   iii. the utilization of per-diem based fees in any agreement with any third party payor.

2. Directly or indirectly communicating any negotiated fee or refusal to grant discounts to any third party payor with any hospital in the Long Island area.

3. Directly or indirectly using Classic Care or any other agent to set, maintain or determine any fee of any hospital in the Long Island area.

Negotiating Group: Not Permitted

4. Defendant Classic Care was enjoined from:
   - i. entering into any agreement with any hospital in the Long Island area concerning the terms or amounts of any fee charged to a third party payor;
   - ii. entering into any agreement with any hospital in the Long Island area to hold itself out as an exclusive negotiating agent with any third party payor;
   - iii. developing, adopting or distributing any fee schedule for use with any third party payor; and
   - iv. recommending that any hospital withdraw from or refuse to enter into any agreement with any third party payor.
5. Each defendant was required to terminate any agreement entered into with any other defendant that conditions actual or possible agreement relating to fees between a hospital and a third party payor on the formal or informal approval, review or acquiescence of any other defendant.
6. Defendants could enter into bona fide integrated joint ventures so long as the joint venture "in no way discourages, impedes or prohibits any participating hospital from negotiating or entering into any agreement independently with any third-party payer.“ However, the defendants must inform the plaintiff (U.S. Attorney General) of the name and address of every joint venture they enter into in the future.

Negotiating Group: Not Permitted

I. In a Department of Justice press release in connection with the Classic Care Network case, the Assistant Attorney General in charge of the Antitrust Division stated "Health care consumers, through their membership in HMOs and managed care plans, rely on competition between hospitals to obtain favorable prices for hospital services and lower health insurance premiums. This administration will enforce the antitrust laws to challenge any arrangement between competing health care providers that has the purpose of reducing competition or raising prices for health care services".

II. More recently, in 2011 letters, the Federal Trade Commission responded to proposed legislation in NY, CT, and TX laws that would exempt eligible health care providers from state and federal antitrust laws and would allow the providers to cooperatively negotiate with MCOs, the FTC stated "the Commission and its staff have long advocated against federal and state legislative proposals that would create antitrust exemptions for collective negotiations by health care providers"

Proposed NY Law – S.B. 3186A-2011

I. Stated purpose: "To restore fairness in the contracting process between health care providers and large managed care plans by allowing such providers to join together to negotiate contract provisions."

II. Was referred to Ways and Means, but would only have been applicable to health care professionals, not institutional providers or agencies.

What is Permitted?

I. The FTC will apply a “rule of reason” test to joint price agreements between providers that are financially or clinically integrated and the agreement is reasonable necessary to accomplish the integration.

   A. Will the collaboration have anticompetitive effects?

   B. Do pro-competitive efficiencies outweigh those effects?

II. Independent Practice Associations

   A. IPA acts as a "middle man", entering into contracts with providers, and then making such providers available to an MCO through a contract with the MCO. The services can be provided for a capitated amount – so that the IPA is sharing risk with the MCO.

   B. The organizational documents of an IPA must be approved by the Commissioner of Health, the Education Department and the Insurance Department prior to filing with the Secretary of State.

   C. The FTC has applies the rule of reason test favorably to IPAs organized by a group of providers, where it has found substantial integration among its participants and the potential to produce “significant efficiencies in the provision of medical services”.

Accountable Care Organizations

III. The FTC and the Justice Department issued its Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program. It states "in light of CMS' eligibility criteria and its monitoring of each ACO's results" joint negotiations with private payors "will be treated as reasonably necessary to an ACO's primary purpose of improving health care delivery". Rule of reason test still applies.

   A. ACOs must not engage in improper exchanges of prices or other competitively sensitive information among competing participants.

   B. Permitted activities will depend on market share of participants.

   C. Can seek expedited 90 day review from FTC and DOJ.