Drafting Managed Care Contracts: Considerations for Providers
Negotiating Favorable Rates and Terms and Anticipating Areas of Dispute

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Today’s faculty features:
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DRAFTING MANAGED CARE CONTRACTS: CONSIDERATIONS FOR PROVIDERS

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OVERVIEW OF DISCUSSION

A. Introduction
B. Key Definitions
C. Provider Obligations
D. Payor Obligations
E. Claims Submission and Reimbursement
F. Retroactive Claim Adjustments, Audits, Recoupments
G. Term and Termination
H. Unilateral Modification of Health Plan Policies and Procedures
I. Dispute Resolution
J. Change of Control Provisions
K. Regulatory Compliance
A. INTRODUCTION

- What is the contracting process?
- Does the contract make sense?
  - Does plan need provider?
  - What does plan bring to provider?
- Know your partner/adversary
  - Plan view: Quality of provider; ability to share risk; reputation; managed care experience; reputation.
  - Provider view: breadth of customer list; potential for growth; claims payment experience; reputation.
A. INTRODUCTION, CONT.

The contract itself
- Who does the drafting?
- Standard terms
  - Federal/state mandated.
  - Claim of no ability to negotiate.
- Rate schedules
- Exhibits and attachments
- Integration clause
  - Documents incorporated by reference.
  - Policies & procedures.
  - Grievances and appeals.
B. KEY DEFINITIONS

- Member/enrollee
  - May vary depending on product.
  - Who is covered?
  - Focus on eligibility.

- Payor
  - Who is responsible for payment?
  - TPA and PPO disavow all responsibility.
B. Key Definitions, Cont.

Covered Services

- Key to what is provided and what is paid.
- Plan view: broad language; tie to medical necessity; right to modify.
- Provider view: clear definition; want an “out;” control over types of service and access.

“Those medically necessary services health care services to which Enrollee is entitled under the Enrollee’s plan.”

“Those services and supplies that are within the scope of provider’s license and that provider is willing to provide based on availability. Provider shall not be required to provide any service that it does not provide to its own patients?”
B. KEY DEFINITIONS, CONT.

Medical Necessity

- Objective criteria.
- Proactively address exceptions.
- Plan view: way to control costs; wants sole discretion.
- Provider view: way for plans to deny payment.
- Exercise of professional judgment cuts both ways.
Medical Necessity

“Plan’s Medical Director shall make all determinations regarding Medical Necessity and the Medical Director’s determination shall be final and binding.”

“Treatment shall be deemed Medically Necessary upon demonstration that such treatment is appropriate and likely to result in demonstrable medical benefit.”

“appropriate and necessary…not for convenience of physician or patient…performed in most cost efficient manner.”
B. KEY DEFINITIONS, CONT.

- **Standard of Care**
  - Hold provider to quality standard
    - Does it include cost efficiencies?
  - How measured?
    - Community standard – What community?
    - Specialist v. PCP
C. PROVIDER OBLIGATIONS

- Render Medically Necessary Covered Services
- Timely Submit Claims for Covered Services
- Accurately Document Covered Services Rendered
- Obtain Pre-Cert Per plan Policies
- Abide By Plan Policies
D. PAYOR OBLIGATIONS

- Attract the customers
  - Key to volume of patients available to provider.

- Establishing provider network
  - Quality and reputation.
  - Credentialing.

- Make payment
  - Coordination of benefit.
  - Prompt pay requirements.

- Manage the care
  - UM/QA.
E. CLAIMS SUBMISSION AND REIMBURSEMENT

- Clean claim
  - Define by kind of claim form.
  - Discretion of plan.
  - Penalty for errors.
  - Evidence of medical necessity.

- Timely submission
  - Penalty for late submission.
  - Waiver of right to payment.
E. Claims Submission and Reimbursement, Cont.

- Payment terms
  - Time period for payment.
  - Payment of only clean claim.
- Right to withhold payment
  - Timeliness.
  - Non-compliance with UM/QA policies.
  - Interest or penalty.
- Coordination of benefits
- Appeals
F. RETROACTIVE CLAIM ADJUSTMENTS, AUDITS, RECOUPMENTS

Payor Audits are on the Rise…

What has been your Experience?
What are the Provider’s Legal Rights?

- Law varies by state.

- For example, New York Insurance Law Section 3224-b Provides:
  - Health Plan must give Providers 30 days’ written notice with specific explanation of proposed adjustment.
F. RETROACTIVE CLAIM ADJUSTMENTS, AUDITS, RECOUPMENTS, CONT.

- Health Plan must provide opportunity to challenge the overpayment recovery, including sharing of claims information.
- Health Plan must provide you with written policy to challenge the overpayment recovery.
F. RETROACTIVE CLAIM ADJUSTMENTS, AUDITS, RECOUPMENTS, CONT.

General Rule-

- Negotiate Plan Can Go Back a defined number of years after original payment was received. However, with reasonable belief of fraud or intentional misconduct, Health Plan may be permitted to go back longer.
F. RETROACTIVE CLAIM ADJUSTMENTS, AUDITS, RECOUPMENTS, CONT.

Exceptions to the General Rule-

- State law rules not applicable to Medicaid or Medicare Plans, or self-insured plans.
F. RETROACTIVE CLAIM ADJUSTMENTS, AUDITS, RECoupMENTS, CONT.

What Strategies Should you Consider?
Limit Look Back Period to 1 year

- The Plan will insist that this limit be reciprocal.

- Make look back limit apply to all lines of business.
G. TERM AND TERMINATION

What is preferable, a 1 year term or a multi-year term?

Automatic renewals:

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<thead>
<tr>
<th>Pros</th>
<th>Cons</th>
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<tr>
<td>No contract interruption</td>
<td>Rates stagnate</td>
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<td>Need a strategy to re-visit rates</td>
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<td>Evergreen leaves no room to re-negotiate rates</td>
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<td>Could prevent you from participating in better rates offered by a</td>
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<td>network you join down the line</td>
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G. TERM AND TERMINATION, CONT.

- Placeholder to re-visit rates annually
- Negotiate annual increases in contract, *however*, be careful with tying it into Medicare rates
- Without cause termination provisions
- Obligations on termination
H. Unilateral Modification of Health Plan Policies and Procedures

- Unilateral right to modify terms in the contract
- Unilateral right to modify the plan’s policies and procedures
- Unilateral right to amend fee schedules
Contract terms may read:

“….Plan may amend the agreement upon 30 days prior written notice to the Provider.”

“For amendments that are not material adverse changes in the terms of this Agreement, Plan can amend this Agreement by providing 30 days advance written notice to Provider.”
“Plan may amend this Agreement or any of the appendices on ninety days written or electronic notice by sending the Provider a copy of the amendment. Provider’s signature is not required to make the amendment effective.”
“..The Plan, at its discretion, may amend the Agreement or Fee Schedule at any time upon 30 days notice. If the amendment is unacceptable to the Provider, Provider may terminate the Agreement upon prior written notice to the Plan.”

“Plan routinely updates its fee schedule in response to additions, deletions and changes to CPT codes by the AMA… Plan will not generally attempt to communicate routine maintenance of this nature.”
Provisions which allow for modifications to the Plan’s policies and procedures:

“The Provider Manual may be amended from time to time upon thirty days prior written notice to the Provider.”

“Plan shall provide the Provider with copies of the policy and procedure manual and all revisions to said policy and procedure manual as they are issued.”

“…Hospital agrees to continuously participate in and cooperate and comply with Health Plan's Program Requirements. Plan shall have the right to modify such Program requirements in its discretion”
What to do?

Make Sure You are Entitled to Formal Written Notice!

Proposed language:

“Health Plan shall provide no less than sixty (60) days’ written notice of a proposed amendment to a Program Requirement.”

“To the extent there are any inconsistencies between the terms of the manual and the terms of the contract, the contract terms shall prevail.”
Consider Modifications that Change the Financial Deal.

Proposed Language: OPTION 1

“Where the modified Program Requirement has the potential to negatively impact the Hospital in a material way, the Hospital shall provide written notice to Health Plan of same within thirty (30) days. Health Plan and Hospital shall meet to discuss the impact of the modification on the Hospital and shall develop a budget neutral resolution.”
Proposed Language: OPTION 2

“Where the modified Program Requirement has the potential to negatively impact the Hospital in a material way, the Hospital shall provide written notice to Health Plan of same within thirty (30) days. Health Plan and Hospital shall meet to discuss the impact of the modification on the Hospital. In the event that Hospital and Health Plan are unable to reach a resolution that is acceptable to Hospital regarding the negative impact, Hospital shall be entitled to terminate the Agreement upon sixty (60) days’ written notice to the Health Plan.”
**Scenario:**

2 MRI’s performed on the same Day, one of the abdomen, one of Chest. Payor pays only 50% of the Second MRI, due to a policy change.

Our argument-this was a modification to the contract adversely impacting reimbursement, *masquerading as a policy change.*
I. Dispute Resolution

What are the Options?

- Litigation
- Arbitration
- Mediation/Arb
I. Dispute resolution, Cont.

- Neutral third party works with the parties.
- Meets individually and then together.
- Lets each know weaknesses.
- Does not render a decision.
- Formal rules do not apply.
I. DISPUTE RESOLUTION - MEDIATION

- **Advantages**-
  - Can reduce antagonism.
  - Good for on-going relationships.
  - Parties can select an expert as the mediator.

- **Disadvantages**-
  - Party may not be serious about resolution.
I. Dispute Resolution - Arbitration

- Neutral hears a dispute and imposes a resolution. Can be industry expert

- Legally binding decision

- Arbitration right must be in contract

- Issue in dispute must be arbitrable - this is specified in the contract
ARBITRATION, CONT.

- America Arbitration Association (AAA)
- American Health Lawyers Association (AHLA)

Submission to AAA of a form and payment, based upon amount in dispute. The form describes the dispute and relief sought.
ARBITRATION, CONT.

- Limited Discovery.


- Award- final decision of arbitrator. Can include basis of decision or not. Arbitrators may be biased to keep their role in an industry.
Health Plans are adding language into their contracts prohibiting providers from joining in any class action cases.

“The parties expressly intend that any dispute relating to the business relationship between them be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with our dispute. The parties agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.”
I. Dispute resolution- Litigation

- Costly
  Losing party to pay litigation costs

- Time Consuming

- Public
J. Change of Control Provisions (Mergers, Affiliations, etc.)

Recently, Health Plans have been adding language to contracts that impact Provider’s ability to enter into strategic affiliations.
J. Change of Control Provisions (Mergers, Affiliations, etc.)

Health Plan Contract Language:

“…Hospital shall not be entitled to elect to non-renew the Agreement upon expiration for at least one year following the approval of the Change of Control.”
J. Change of Control Provisions (Mergers, Affiliations, etc.)

Health Plan Contract Language:

“…In the event Medical Provider is acquired or merges with another provider under contract with Plan, this Agreement and the other agreement each will remain in effect and will continue to apply as they did prior to the merger or acquisition….”
J. CHANGE OF CONTROL PROVISIONS (MERGERS, AFFILIATIONS, etc.)

Health Plan Contract Language:

“…In the event of Hospital’s acquisition of an entity and such entity has an agreement in effect with Plan, then such entity shall not become a participating provider under this agreement, but rather the separate agreement with Plan shall control for its duration…..”
J. CHANGE OF CONTROL PROVISIONS (MERGERS, AFFILIATIONS, etc.)

Health Plan Contract Language:

“...In the event that Hospital has entered into an agreement with an IPA, now or in the future, which has an agreement with Plan, Plan may in its sole discretion elect which agreement shall govern.”
K. REGULATORY COMPLIANCE

- Government requirements
  - Licensing conditions
  - Medicare Advantage/Medicaid

- Anti-kickback
  - Federal and state laws
  - Watch for improper incentives; marketing techniques; referral arrangements
  - Payments to limit or reduce care

- Beneficiary inducements
K. REGULATORY COMPLIANCE, CONT.

- Antitrust
  - Closed panels
  - Most favored nation provisions
  - Exclusive arrangements

- Tax
  - Exempt plan – excess compensation