

Succeeding in a Managed Care Environment

presented by:

Adam J. Falcone, Esq.

of



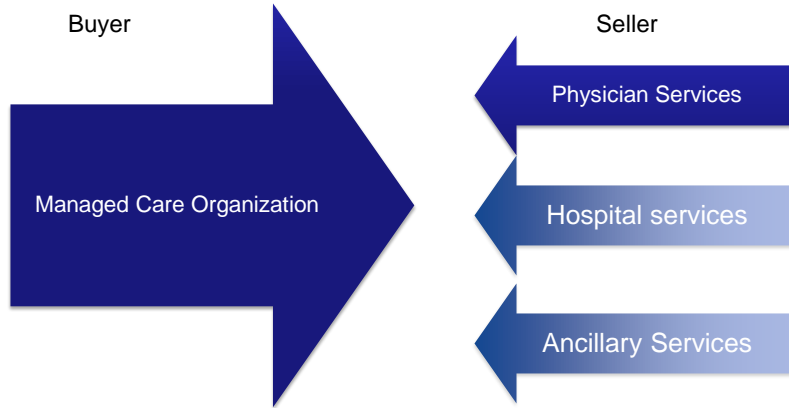
© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

Evolving Health Care Marketplace

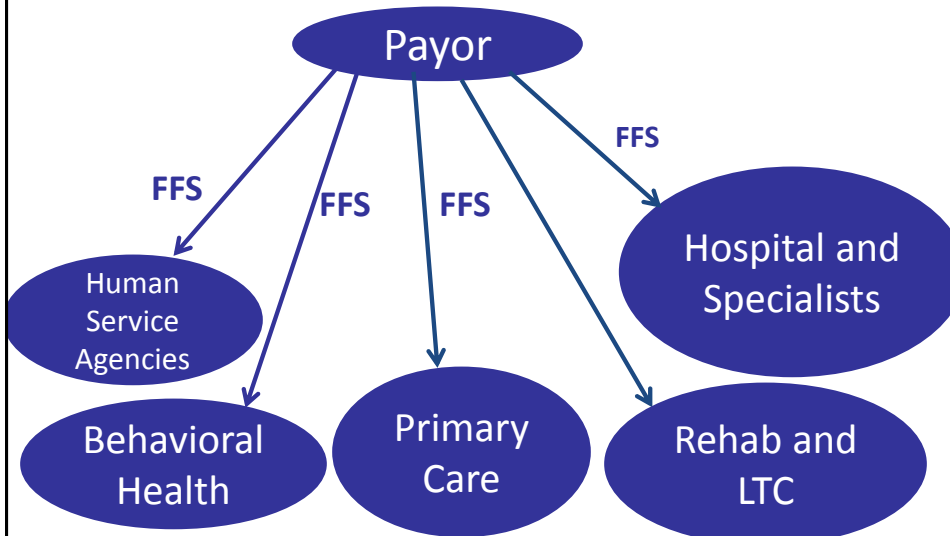
- Health Reform and Competition
- Accountable Care Organizations (ACOs)
- Payment Risk Models (including Shared Savings)
- Participating/Evaluating ACO Opportunities



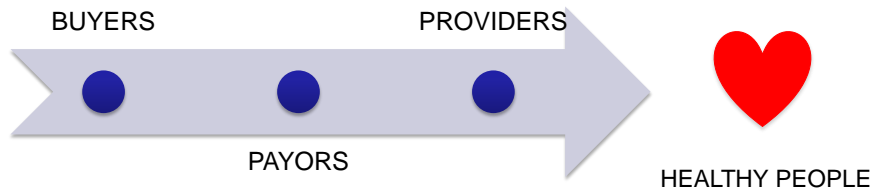
Health Services Marketplace (Today)



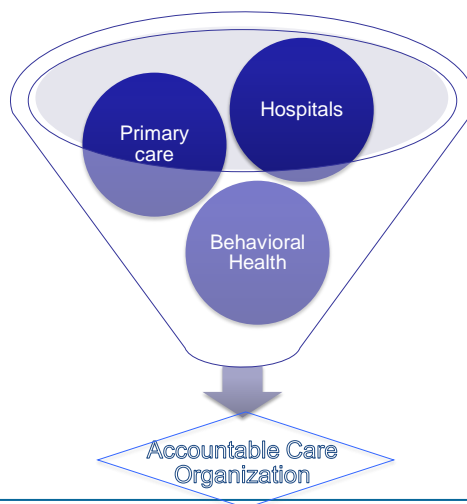
Fee-for-Service System



Alignment of Financial Incentives



Accountable Care Organization (ACO)



Accountable Care Organizations

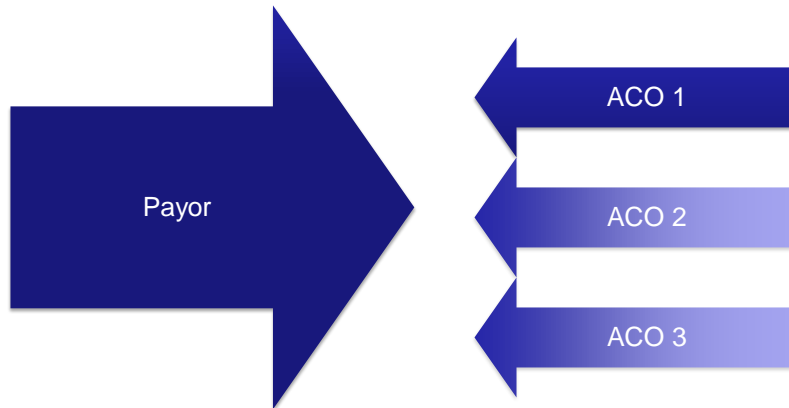
“Networks of physicians and other providers that could work together to improve the quality of health care services and reduce costs for a defined patient population.”

- Health Affairs, Robert Wood Johnson Foundation, Health Policy Brief, *Accountable Care Organizations. Under the health reform law, Medicare will be able to contract with these to provide care to enrollees. What are they and how will they work?* (July 27, 2010)

Basic Features of the ACO

- Combination of one or more hospitals, physician groups (primary care and specialty), and other providers
- Local accountability
- Financial incentives to meet quality benchmarks or cost-savings
- Shared governance structure
- Formal legal structure that allows organization to receive and distribute payments to participating providers
- Leadership and management structure that includes clinical and administrative systems
- Performance measurement

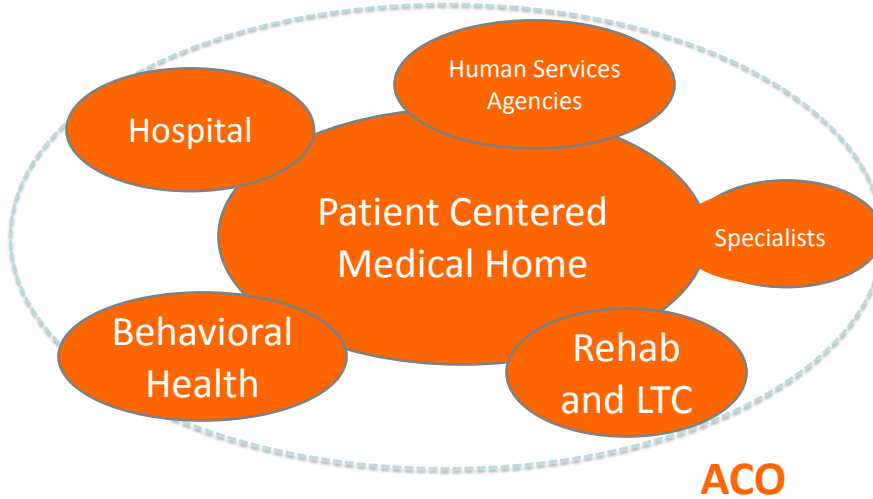
Delivery System Reform



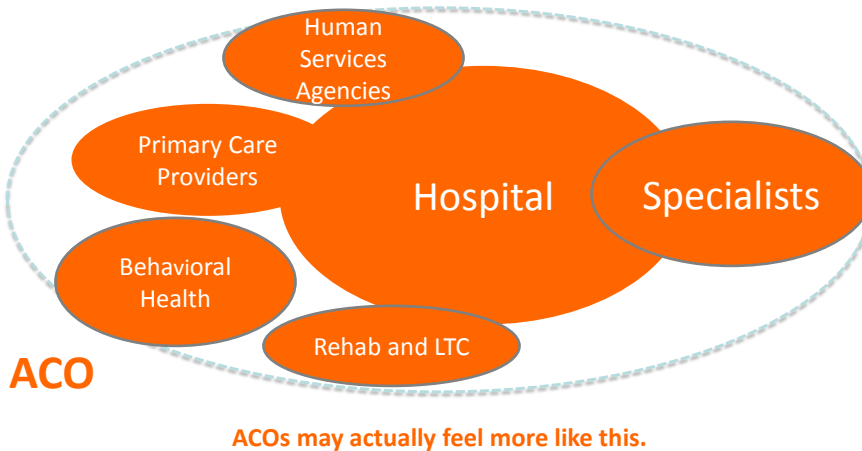
Accountable Care

- **Primary care is at the heart of accountable care.**
 - The patient-centered medical home model emphasizes holistic, integrated primary care in order to improve patient outcomes and decrease health care costs.
 - Human service organizations are valuable partners in providing this type of care because of their experience in serving populations with complex needs, employing a community-based approach, and reducing negative impact of social determinants of health.

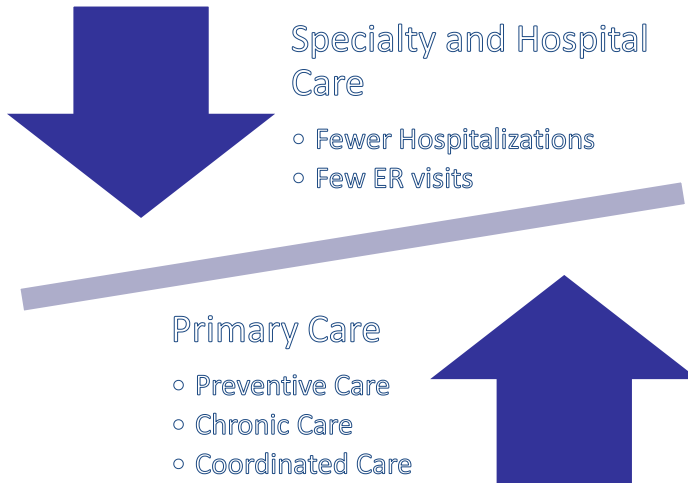
Accountable Care Organization



Accountable Care Organization



ACO Financial Incentives



Medicare Shared Savings Program

- ACO: Groups of providers, organized as a separate legal entity, who work together to manage and coordinate care for Medicare FFS beneficiaries (called an Accountable Care Organization).
- Entities eligible to form ACOs:
 - ACO Professionals (MD, PA, NP, CNS) in group practices
 - Networks of individual practices of ACO Professionals
 - ACO Professional/Hospital Joint Ventures
 - Hospitals employing ACO Professionals
 - Certain CAH
 - FQHCs and RHCs
- PCP Participation
 - **Cannot participate in more than one Medicare ACO**
 - Each ACO participant TIN must be exclusive to one ACO
- Medicare Beneficiaries
 - Must serve at least 5,000 beneficiaries

Medicare Shared Savings Program

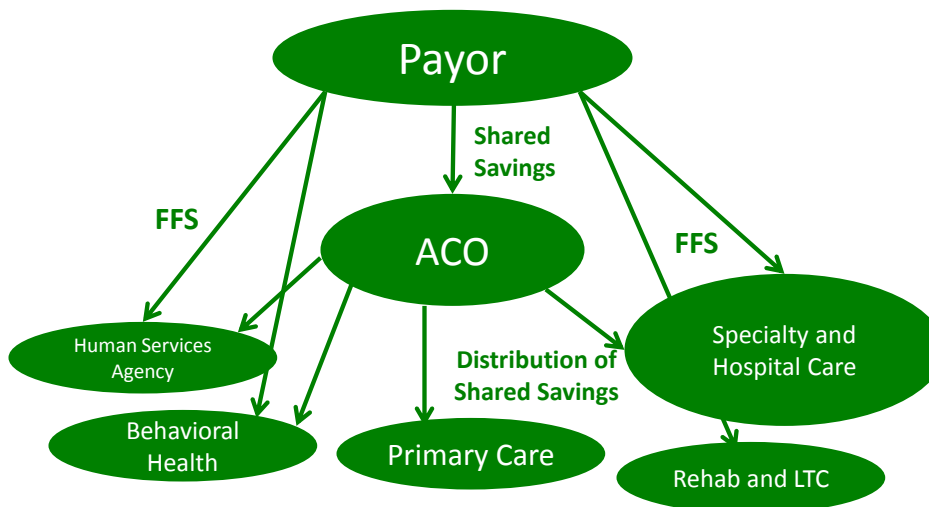
Mechanism for Shared Governance

- ACO participants must control 75% of governing board
- Proportional representation NOT required in final rule

Beneficiary assignment (attribution)

- Based on whether beneficiary served by a physician participating in an ACO
- If so, assigned to ACO that beneficiary receives a plurality of primary care services
 - Services rendered by primary care physicians with a designation of internal medicine, geriatric medicine, family practice, and general practice
 - Services rendered by other ACO professionals (NPs, PAs, CNSs)
- CMS uses most recent 12 months of data to identify beneficiaries that could potentially be assigned to ACO
 - Final assignment based on data from end of each year

ACO: Shared Savings Model



ACO: Shared Savings Model

Checklist of Key Questions

Risk

- Upside only?
- Downside risk? How much?
- How will downside losses be paid for?

Shared Savings

- How much of the savings will be shared (or retained by the ACO)?
- Who decides distribution of savings among participants?
- What have hospital/specialty partners contributed?

PCMH Activities

- What investments will the ACO make in the PCMH?
- How much input on clinical pathways/guidelines?
- What quality metrics will be used?



Medicare Shared Saving Program

Shared Savings Determination

- Benchmark: Estimate of what total Medicare FFS expenditures for ACO beneficiaries would have been in absence of ACO

Risk Models

- Track 1: One-Sided Model – No down-side Risk
 - All three years: shared savings only
 - Shared savings up to 50%
- Track 2: Two-Sided Model – Upside and Downside Risk
 - All three years: shared savings and risk of loss
 - Shared savings up to 60%

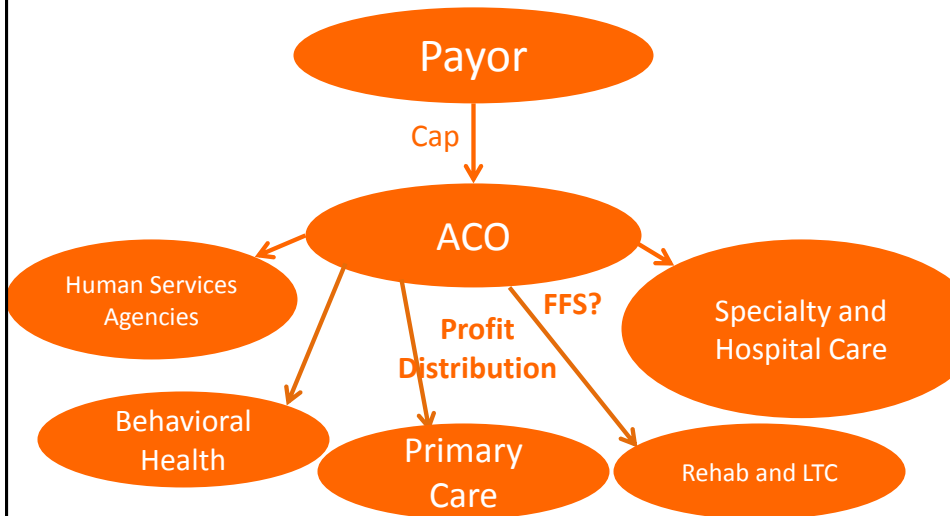
Medicare Shared Saving Program

- Distribution of Savings and Repayment of Losses
 - ACO must describe its method of distribution in ACO application
 - Subject to CMS approval, ACO would decide how to fund repayment to CMS of potential losses, e.g., recovering funds from ACO participants, reinsurance, escrowing funds, surety bonds, or line of credit.
 - ACO would be required to disclose in application the percentage of shared losses that each ACO participant would be responsible for repaying.
- Advanced Payment Initiative
 - “Tests” whether pre-paying portion of future shared savings would increase participation in MSSP.
 - Eligible organizations would receive an advance on shared savings expected to be earned which be recouped through ACO’s earned shared savings, if any.

Pioneer ACO Model

- The Pioneer ACO Model is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings.
 - Allows provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the MSSP.
- Shared savings and losses during first two years
 - Higher levels of savings and losses than MSSP
- Population-based payment (i.e. capitation) beginning in third year, with option for two more years
- Must serve at least 15,000 beneficiaries
- Providers cannot participate in both MSSP and the Pioneer ACO Model

ACO: Full Risk Capitation Model



ACO: Full Risk Capitation Model

Checklist of Key Questions

Risk

- How will downside losses be paid for?
- What if ACO runs out of money?

Profit Distribution

- How much of any profits will be shared?
- Who decides distribution of profits among participants?
- What have hospital/specialty partners contributed?

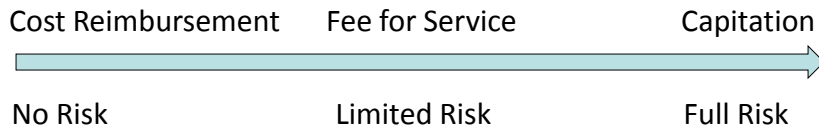
PCMH

- What investments will the ACO make in the PCMH?
- How much input on clinical pathways/guidelines?
- What quality metrics will be used?



Concept of “Risk”

- Risk versus non-risk contracts
- Common feature of “risk” contracts is that provider is not guaranteed that payment for services under the contract will fully cover the provider’s costs
- Spectrum of risk:
 - No risk: provider is reimbursed on a cost basis (unheard-of in managed care)
 - Limited risk: payments to the provider are based on a pre-established fee schedule (“fee for service” payment)
 - Full risk: provider is paid a monthly lump sum per patient (“capitation” payment)



Provider Reimbursement Methods: Fee-for-Service

- Provider agrees to a fee schedule (typically, with a different fee for each service)
- Provider submits to MCO a retrospective claim for each service provided
- High volume of service usage, or usage of costlier services, benefits the provider, since each service is billed separately
- Revenues increase as more services are provided



Provider Reimbursement Methods: Fee-for-Service

- Main **advantage** of fee-for-service payment is predictability
- **Disadvantages** of fee-for service payment:
 - Burdensome claims submission process
 - Payment disputes arising where MCO determines claim submitted not to be a “clean claim”
 - Provider responsibilities relating to coordination of benefits (identifying third-party payors)



Provider Reimbursement Methods: Fee-For-Service



Fee-for-service reimbursement may be the best arrangement for a provider when it cannot confidently predict the costs of providing care. This may occur:

- When the contract with the MCO covers only a limited range of services, so the provider cannot control overall costs of care
- When the provider does not have significant experience furnishing the services covered under the contract or patients with needs similar to those of the MCO's enrollee base

Provider Reimbursement Methods: Capitation

- Provider receives prospective flat payment for each enrollee per month (“**per member per month,**” or **PMPM,** payment)
- Payment does not vary according to number or nature of services provided
- Number of enrollees in provider’s **panel,** rather than the actual utilization of services, dictates payment



Provider Reimbursement Methods: Capitation

Advantages of capitation:

- Non-clinical services, such as case management, can be taken into account in payment
- Disputes over payment less likely to arise under capitation than under fee-for-service

Disadvantages of capitation:

- Unpredictability
- Capitation may encourage providers to ration treatment in order to contain costs



Provider Reimbursement Methods: Capitation

A provider is more likely to have a positive experience with capitation payments when:

- The contract with the MCO includes the full or almost-full scope of provider's services
- The mix of patients included in the MCO's enrollee base is similar to provider's current patient base
- The PMPM payment includes only services that are under the provider's control



Provider Reimbursement Methods: Withholds

- Amount withheld from the MCO's fee-for-service or PMPM payments to the provider
- Typically used to motivate provider to meet utilization control or quality standards
- PMPM or portion of fees withheld throughout year; at year's end, MCO determines whether provider met established goals



Provider Reimbursement Methods: Care Management Fees

- **“Primary care medical home” (PCMH) model:** each patient has a relationship with a PCP who serves as patient’s first contact
- PCMH programs encourage PCPs to provide care management and other enabling services
- Recent years have also seen rise in “disease management” programs in which PCP is required to implement plan of care addressing chronic condition
- A per-member-per-month fee often used by payors or MCOs for care management services when the provider is otherwise paid on fee-for-service basis



Provider Reimbursement Methods: Pay for Performance (P4P)

- **P4P** links payment to the quality of care provided by clinicians using both incentives and penalties
- P4P benchmarks can be outcome-based (were certain clinical goals achieved or negative outcomes avoided?) or process-based (did the physician comply with protocols?)
- Quality measures typically based on nationally-recognized measures such as the Healthcare Effectiveness Data and Information Set (HEDIS) and the Consumer Assessment of Healthcare Providers and Systems (CAHPS)



Provider Reimbursement Methods: Shared Savings



- **Shared savings programs** use incentive payments to reward provider's reduced costs for a population
- MCO or payor establishes baseline annual anticipated expenditures per enrollee; if average cost per patient is lower than the baseline, provider receives incentive payment
- To ensure that incentive does not negatively impact care, shared savings payment may be contingent on satisfying quality standards

Evaluating ACO Participation Agreements

Risk

- Upside only?
- Downside risk? How much?
- How will downside losses be paid for?



Shared Savings

- How much of the savings will be shared (or retained by the ACO)?
- Who decides distribution of savings among participants?
- What have hospital/specialty partners contributed?

Primary Care/PCMH

- What investments will ACO make in primary care?
- How much input on clinical pathways/guidelines?
- What quality metrics will be used?

ACO Participation Agreements

Key contract issues:

- Definition of Provider/Medicare NPIs
- Payment Arrangement / Shared Savings
- Membership / Exclusivity / Opt-Out
- Indemnification
- Information Technology

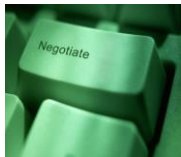
Negotiating From a Position of Strength

- Assessing Leverage
- Marketing to Health Plans and Networks
- Competing Based on Value
- Establishing a Provider Network



Assessing Leverage

- Assessing leverage is a key component of a successful negotiation
 - If the MCO is required by law to include the services in its network, and there are few providers offering those services, then the MCO is more likely to respond positively to proposed contract modifications
 - Keep in mind (and make sure that the MCO is aware of) your internal strengths and abilities
 - ability to deliver cost-effective, quality services promptly and reliably
 - access to target populations
 - ability to monitor and control utilization, costs and quality assurance



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Past Performance

Past performance of the MCO

- If applicable, gather information about past experience of the provider with this MCO:
 - Did the MCO meet its payment obligations on time?
 - Was the number of denied claims excessive?
 - Did the MCO give the provider a role in the development of policies, such as utilization review?
 - Was the MCO responsive to the provider's requests?



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Negotiating Collectively



- Because of antitrust concerns, providers **may not negotiate together** as a group with MCOs
- Providers must make **independent, unilateral decisions** on whether to accept contractual terms
- **Under certain circumstances**, providers can increase leverage through size and negotiate as a single unit as:
 - IPAs and networks
 - Group practices
 - Integrated delivery systems

Marketing to Health Plans

- What do health plans (payors) want?



Marketing to Health Plans

What are the problems in the delivery system?

- Focus on volume and profitability
- Fragmented system organized by specialty
- Quality defined by process compliance
- Cost accounting driven not by costs but charges
- FFS payments by specialties
- Delivery systems with duplicative services lines and little integration
- Fragmentation of patient populations
- Siloed IT systems

Marketing to Health Plans

- How do we get there?
 - Shift focus to patient outcomes achieved
 - How?

Competing on Value

What is the “Value Agenda”?

- 1) Organize into Integrated Practice Units
- 2) Measure Outcomes and Costs for Every Patient
- 3) Move to Bundled Payments for Care Cycles
- 4) Integrate Care Delivery Across Separate Facilities
- 5) Expand Excellent Services Across Geography

Michael Porter and Thomas H. Lee, “The Strategy that Will Fix Health Care”, *Harvard Business Review*, October 2013.

Michael Porter and Elizabeth Teisberg, *Redefining Health Care* (2006).



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

43

Strategic Positioning

- Inventory strengths/capabilities
 - Temperament to accept risk?
 - Ability to manage risk?
 - Board support?
- Identify potential partners
 - Medicaid Managed Care Plans, Safety-Net Plans, Commercial Plans
 - Existing Partners / Affiliations
- Formulate potential collaborations
 - Review financial, operational and legal considerations
- Make proposal to Partners and/or Payors

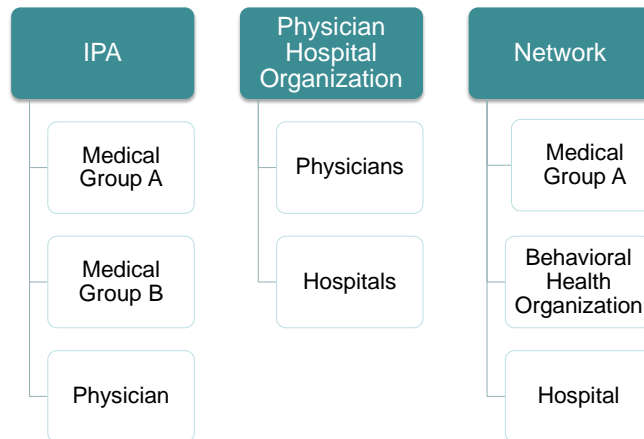


© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

44

Types of Provider Networks



Functions of an IPA / Network / ACO

- Network participants might consider forming a network to engage in any of the following activities:
- **Shared Support Services**
 - IT Support for Electronic Health Record (EHR)
 - Health Information Exchange (HIE)
 - Credentialing practitioners; exclusion/debarment background checks
 - Third-Party Billing
- **Managed care contracting**
 - Marketing network of behavioral health care
 - Facilitating managed care contracting
 - Negotiating capitated risk contracts
 - Negotiating shared savings arrangements

Provider Networks

- Major antitrust issue is collusion (price fixing, boycott) in collective negotiations with payors
- Concern is that provider networks will use market power to increase rates, driving up costs for payors, and ultimately, for consumers
- Mixed message from FTC?
 - “If you fix prices– that is, if independent doctors jointly negotiate the fees they charge– we will make you stop. But if you join together to improve patient care and lower costs, not only will we leave you alone, we’ll applaud you.”
 - - FTC Chairman Jon Leibowitz (June 14, 2010)

Antitrust “Safety Zone”

FTC/DOJ Statements of Antitrust Enforcement in Health Care

- Statement 8 - Creates “safety zone” for provider networks that allows a network to negotiate and contract with third parties as a single entity on behalf of its participants and to engage in other activities typically considered anti-competitive, if the participants are sufficiently integrated.
- Financial Integration: substantial financial risk-sharing by network participants in providing all the services that are jointly priced through the network
 - Capitation, percentage of premium, or significant financial incentives
- Market Share Limitations
 - If the collaboration is non-exclusive, it must be comprised of no more than 30% of the primary care or specialty physicians in the relevant market
 - If the collaboration is exclusive, it must be comprised of no more than 20% of the primary care or specialty physicians for the relevant market.

Clinical Integration

- “Rule of Reason” test applies to determine whether providers’ integration through the network is likely to produce significant efficiencies that benefit consumers and the price agreements by the network physicians are reasonably necessary to realize those efficiencies.
- Clinical Integration: Active and on-going programs to evaluate and modify clinical practice patterns of all network providers
 - High degree of interdependence and cooperation among all network providers to control costs and ensure quality care
 - Share patient clinical information
 - Develop and implement practice protocols
 - Monitor performance to improve outcomes and control costs
 - Sanctions for non-compliance
- FTC issues Advisory Opinions to guide organizations on clinical integration

Antitrust Legal Considerations

- Non-integrated provider networks— even separate legal entities (e.g., IPA, PHOs)— must rely on so-called messenger model to contract with payors unless there is:
 - Substantial financial risk sharing (e.g., capitation, shared savings, etc.)
 - Clinical integration among providers
- DOJ and FTC provide guidance to public and have approved certain provider collaborations that comply with antitrust laws.

Preliminary Considerations

- Form should follow Function
 - Behavioral health organizations should determine the activities of the network before they decide on type of corporate entity or governance structure
 - Change in function should equal change in form

Legal Structure

Full Integration

- System owns hospitals and employs salaried physicians

Partial Integration

- Joint ownership or joint control of new legal entity (e.g., IPA, PHO)

Joint Venture

- Contractual relationships (e.g., affiliation)
- Joint governance committee

Alternatives to Forming a New Entity

- Unincorporated Associations
 - Loosely formed group
 - Unlike more formal entities, they are not bound by state requirements concerning governance and decision-making processes.
- State Association
 - Pro: Already exists
 - Con: Not all members may want to participate
 - Con: Could incur significant financial or legal risk

Advantages of Forming a Separate Legal Entity



- Shields each owner from liability for debts, obligations and other liabilities of the network and other owners
- BHOs retain control over their own operations because shared control only extends to network's joint activities
- BHOs maintain their independence and autonomy while working together
- BHOs can pool resources to make joint investments in information technology, clinical or financial expertise, or equipment

Capitalizing the Network

- A non-profit's investment in a joint venture should be reasonable in terms of:
 - the risk of its capital contribution and the likelihood of an expected return or benefit to the non-profit organization of membership
 - the relationship between the proposed activities of the network and the non-profit's charitable purpose.

Choice of Legal Entities

- Legal entities generally available under state law:
 - General business corporation (For-Profit)
 - Non-profit organization
 - Limited liability company (LLC)

Smart Managed Care Contracting

- Reviewing the Contract
- Key Financial Issues
- Key Operational Issues
- Key Clinical Issues



Managed Care Contract Review

- Before you sign,
use the P.E.N!
- **P**repare
- **E**valuate
- **N**egotiate



Prepare



- Assemble review team
 - Establish “point person” and review team lead
 - Assign areas of contract review to team members based on expertise

Prepare

- Assemble documents
 - Obtain entire proposed contract (or contracts) from MCO, including all referenced and incorporated documents
 - Don't assume MCO knows your scope of services!
 - Obtain other documents necessary to understand legal obligations (for example, in Medicaid managed care, the MCO's contract with the State)
 - “Managed Care Model Contracts” available at:
http://www.health.ny.gov/health_care/managed_care/providers/index.htm

Evaluate

- Understand what all provisions mean
- Ensure that responsibilities are clearly stated and all terms are unambiguously defined
- Ensure all policies, procedures and documents referenced in the contract are included in or accompany the contract (or can be easily and directly obtained)
- Ensure that any references to statutes, codes, regulations etc. are precise
- Ensure that the contract and all requirements and responsibilities comply with all applicable Federal and State laws, regulations and policies
- Ensure contract reflects sound business judgment



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Evaluate

- After reviewing the entire agreement, consider the following issues
 - Does the contract include the key elements identified during the preparation phase?
 - Which other elements of the contract are critical?
 - What liabilities are created by particular provisions (or terms within provisions)?
 - What modifications are critical – terms without which the provider cannot afford to proceed because the risks (not just financial) are unacceptably high?
 - How can modifications be drafted so that they are fair to both parties and do not frustrate fundamental objectives of the parties? In other words, can the parties find a common ground, and preferably, a "win-win" situation?



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Negotiate

- Preliminary questions
 - Who will be negotiating?
 - A team?
 - An individual?
 - How will terms be negotiated?
 - In writing?
 - By phone?
 - In person?



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Negotiate

- Keep things friendly, not personal
- Focus on underlying interests, not positions
- Do not feel pressured to agree or sign anything while at the “negotiating table”
- Prioritize issues
- Develop options for a “win-win”
- Know “make it or break it” positions



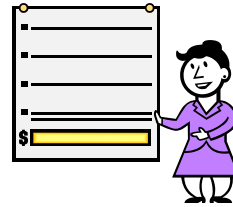
© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Negotiate

When to Walk Away

- Set a “bottom line” based on factors including
 - the importance of the MCO contract to the provider’s operation
 - the extent to which the contract embodies the provider’s goals and objectives
- It may be best to walk away if the provider does not trust the MCO or if the two are not a good “fit”
- The provider must walk away from any contract that does not pass legal muster in its final form (for example, it includes provisions that are inconsistent with or contrary to specific legal requirements)



Claims Submission and Processing

- Clean Claims and Prompt Payment
- Retroactive Disenrollment and Recoupments
- Fraud and Abuse Risks
- Coordination of Benefits
- Dispute Resolution



Documentation of Claim

- MCOs typically retain right to audit provider's records to verify that the **medical record substantiates the claim**
- From the MCO's perspective, if the provider cannot substantiate the claim, it is as if the services were never rendered
- The provider should ensure that practitioners rendering the services follow these guidelines:
 - Medical records should be clear, comprehensive, and legible
 - Entries on the record should be dated and signed by the practitioner
 - If the practitioner requires supervision, the supervising practitioner should also date and sign the medical record



False Claims Act (FCA)

- The primary mechanism used by the federal government for penalizing fraudulent health care billing and coding practices
- The law prohibits **knowingly submitting or causing to be submitted false claims for payment** by the federal government
- FCA penalties apply both to claims made directly to federal programs **and to the billing of MCOs that contract with those programs**
- Fraud Enforcement and Recovery Act ("FERA") of 2009: A person can be liable under the FCA for knowingly submitting a false claim for payment to a government contractor, if any portion of the money used for the payment comes from the federal government



False Claims Act (FCA)

Now You Know it. Now You Don't.



- In general, a false claim or statement under the FCA requires “knowledge”
- However, the FCA **broadly defines “knowledge” to include deliberate ignorance or reckless disregard** of the truth
- Implication: Repeated submission of claims that contain billing errors without making any attempt to prevent future errors from re-occurring may be found to have submitted the claims with “reckless disregard” of the truth or falsity of the statement

False Claims Act: Penalties

- Fines under the FCA may be up to \$11,000 per false claim, plus up to three times the amount of damages that the Government sustained as a result of the improper acts
- A provider found to violate the FCA can be **excluded from participating in Federal health care programs** (e.g., Medicare and Medicaid)
- The FCA allows private individuals to bring false claims actions in the name of the Government (**qui tam** action; the people bringing the actions are known as relators, or whistleblowers)



Corporate Compliance Programs

- In the area of fraud and abuse in public programs, the ACA:
 - Dedicates funding to fraud & abuse enforcement
 - Enhances penalties for fraudulent conduct
 - **Mandatory compliance programs as a condition of enrollment in Medicare, Medicaid, and CHIP**
 - **New York Medicaid Program mandates compliance programs!**



Corporate Compliance Programs

- A corporate compliance program can help to achieve the following goals:
 - Improves quality, efficiency, effectiveness of health care services and operational activities, while reducing costs
 - Demonstrate commitment to compliance and honest conduct
 - Potential mitigation of penalties if non-compliance occurs

Corporate Compliance Programs

A Compliance Program helps to identify and proactively address compliance risks in the following areas:

- Medical record documentation (coding)
- Claims submissions (billing)
- Preventing the employment or contracting with suspended or excluded individuals and entities



MCO Timely Claiming Rules



- The contract should allow a sufficiently long window for the provider's submission of claims to the MCO (at least 60 days)
- Providers should check the proposed contract for provisions concerning the **consequences of late claim submission**
- The provider should negotiate for a provision that makes MCO denial of late claims discretionary rather than mandatory

“Clean Claim” Rules

- Contracts with fee-for-service reimbursement typically make payment contingent on the filing of a **clean claim**
 - “Clean claim” is a claim that can be processed by the MCO without requesting any additional information from the provider or a third party
- The contract should clearly define “clean claim,” and attach approved forms and an instructional manual
- Providers should be wary of provisions giving the MCO the right to “re-bundle” codes or otherwise modify submitted claims according to the MCO’s payment protocols, in order to make the claim conform to “clean claim” standards



Prompt Payment Rules

- Just as the MCO has an interest in timely claims submission, the provider has an interest in timely payment!
- The contract should include a prompt payment provision
 - In fee-for-service contracts, number of days from submission of claim (30 to 45 days is typical)
 - In capitation contracts, fixed date for prospective PMPM payment (typically by 5th day of month that the payment covers)
- The contract should impose interest on the MCO for late payments to the provider

**THANK
YOU!**
YOUR PROMPT
PAYMENT
IS APPRECIATED.

Third-Party Liability Responsibilities

- The provider's contract with the MCO should address which party is responsible for:
 - identifying liable third-party payors (for example, worker's compensation or employer-sponsored insurance), and
 - seeking reimbursement from those payors
- Ideally, the MCO bears both responsibilities
- If the contract imposes on the provider any responsibility for identifying and collecting TPL, the provider should not bear the financial risk of non-payment by a third party



Correction of Overpayments and Underpayments



- MCO contracts typically allow the MCO to recoup **overpayments** (excess payment by the MCO to the provider)
- Contracts commonly permit the MCO to recoup an overpayment by **offset**; the MCO subtracts the overpayment from any amounts due to the provider
- The contract **should not allow** such an offset until the MCO has given the provider notice of the alleged overpayment and afforded the provider an opportunity to appeal the determination
- The contract should also permit the provider to dispute **underpayments**

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
 - Informal negotiation
 - Mediation
 - Arbitration (binding or non-binding)
- The contract should **not** require the provider to exhaust an appeals process within the MCO before resorting to other measures



Managed Care Checklist

Provider guidance in the preparation of MCO contract provisions:

- The contract should establish clear timelines for payment of claims and penalties for late payment.
- A specific definition of a “clean claim” and associated forms and instructional manuals on claims submission should be provided with the contract.
- The contract should include a reasonable timeframe (not less than 60 days) for the provider’s submission of claims to the MCO.
- The contract should impose a deadline on the MCO’s payment of claims (not greater than 45 days after submission) and should impose interest for late payment of claims. In the capitation setting, payment by the MCO should be required early in the month that that payment covers.

Managed Care Checklist

- The contract should require the MCO to be responsible for collecting all payments due from third-party payors.
- The MCO should be obligated to assure payment to the provider in situations in which there is third-party liability.
- The contract should not include provisions allowing unilateral recoupment of overpayments by the MCO, nor allow the MCO to offset any overpayments against future claim payments.
- The contract should not include provisions that allow the MCO to unilaterally change the terms of payment.
- Any change to the fee schedule or capitation payment should be negotiated and agreed to by the parties. The provider should try to negotiate for an automatic annual increase in fees or in the capitation payment.
- The contract should specifically provide for a dispute resolution process that includes graduated steps (including informal negotiation, mediation, and arbitration).

Managed Care Checklist

In agreeing to MCO contracts, provider should be:

- Familiar with the billing rules of each payor to which the provider submits claims for payment.
- Familiar with the False Claims Act, the General Health Care Fraud Statute, and with billing and coding practices that can be risk areas for violations of these laws.
- Prepared to regularly review patient accounts for credit balances and overpayments and timely return any overpayments, particularly those involving Medicare or Medicaid funds.
- Regularly reviewing whether practitioners' licensure is current
- Screening practitioners (as well as all other individuals affiliated with the provider) for exclusion from government health care programs.
- Prepared to implement a system to ensure that claims for payment are submitted to MCOs only for services rendered by practitioners who meet each respective MCO's criteria for payment.
- Prepared to conduct regular pre-submission claims audits to ensure compliance with coding and billing rules and MCOs' criteria for payment.
- Prepared to conduct regular medical record reviews to ensure that documentation substantiates claims for payment.

Easily Overlooked Provisions and Problematic Clauses



- Enrollee Assignment
- Patient Steering
- Change of Providers
- Collection of Co-Payments
- “All Products” Clauses
- Scope of services
- Covered Services
- Referral Policies
- Gag Clauses
- Access Standards
- Termination
- Breach and Cure
- Coordination of benefits / Third Party Liability
- Post-termination responsibilities
- Amendments
- Governing law

Enrollee Assignment



- **Assignment** is the process whereby an MCO matches enrollees to specific primary care providers (PCPs)
 - Assignment determines which PCP the enrollee may visit for services
 - Enrollees who have been assigned to a provider are known as the provider's **panel** of patients
- Assignment may be based based on:
 - Member's previous relationship with physician
 - Family member's relationship with physician or
 - Member's request
 - MCO's preference (auto-assignment)

Patient Steering

- Assignment may also be based on the provider's performance. The term **steering** is typically used today to refer to provisions that allow an MCO to steer enrollees toward certain providers as a reward for the provider's meeting certain benchmarks



Enrollee Assignment

Too Few Enrollees

- If the panel is too small, the provider's costs of participation may exceed the financial benefit.

Too Many Enrollees

- If too large, assignment may strain its capacity.



Enrollee Change of Providers



- While most contracts contain provisions dealing with enrollment into and disenrollment from the managed care plan, some fail to address the need for a procedure to handle the transfer of an enrollee to another provider within the MCO.
- Some of the reasons you may want to transfer an enrollee include:
 - Behavior of an enrollee (e.g., disruptive, unruly, abusive or uncooperative)
 - Any other reason which impairs the provider's ability to furnish services to either that Enrollee or other Enrollees.

Administrative Responsibilities in Managed Care

- Fee-For-Service
Medical services
- Managed Care
- Eligibility and Enrollment Verification
- Service Delivery Standards
- Referrals



Eligibility Verification

- In managed care, the phrase **eligibility verification** is typically used to refer to the provider's responsibility to verify that a patient is properly enrolled with the MCO before the provider renders care.
- Eligibility verification must occur at **every patient visit**.



Contract Review Checklist

- ✓ **Maximum Panel Size:** Does the contract include a provision giving the provider a right to notify the MCO that it has reached its patient capacity (without specifying what that capacity is), and to cap enrollment at that point?
- ✓ **Minimum Panel Size:** Does the contract include a provision requiring the payment method to switch from capitation to fee-for-service if the panel falls below the minimum?
- ✓ **Member Verification:** Does the contract impose on the MCO the risk for errors in the MCO's eligibility verification?
- ✓ **Enrollee Change of Providers:** Does the contract allow the provider to transfer an enrollee to another primary care provider for cause?

Collecting Patient Cost-Sharing

- As in traditional Medicare and Medicaid, the provider is **responsible for collecting cost-sharing** (copayments, coinsurance, and deductibles) required under the terms of the enrollee's plan.



- **Practice Pointer:** Cost-sharing should be collected at the time of the visit, either before or after services are rendered.

Waiver or Reduction of Cost-Sharing

- In general, providers may not reduce the amount of cost-sharing owed.



- Providers should be aware that a routine practice of discounting or waiving these obligations for all patients should be avoided, as it opens the provider up to potential liability on numerous fronts.

Beware of “All Products” Clauses

- MCOs often participate in plans offered by different payors (private commercial insurers, Medicare Advantage, Medicaid, workers’ compensation, etc.)
- MCOs sometimes include an “all-products” in contracts with providers, requiring the provider to participate in all plans offered by the MCO (currently and prospectively)



Contract Review Checklist

- ✓ **Cost-Sharing:** Does the contract require the MCO to supply the provider with up-to-date information concerning cost-sharing?
- ✓ **Cost-Sharing:** Does the contract provide a resource for the provider to consult if it cannot determine a particular patient’s cost-sharing liability?
- ✓ **Waiver and Reduction of Cost-Sharing:** Does the contract permit the provider to discount or waive cost-sharing obligations?

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 payor.



- The **scope of services** section of the contract specifies which covered plan services the provider is responsible for providing.

Covered Services



- It is important to distinguish the scope of services included in the provider's contract with the MCO, from **covered services** (the services available to the enrollee under the MCO's plan).
- Sometimes, groups of enrollees have different benefits plans; not every service falling in the provider's scope of service under the contract is covered under a particular enrollee's benefit plan.
- The contract should make clear that the provider may treat enrollees as private-pay patients for purposes of providing non-covered services.

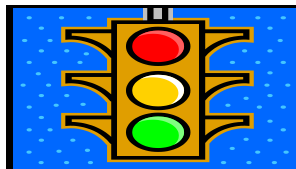
How Services Are Provided

- The contract should clearly state any limits on *how* services can be provided by the provider, including
 - Limitations on which types of clinicians may provide certain services
 - Limitations on the provider's ability to arrange for services through subcontract



Referral Policies

- The MCO contract will likely contain provisions specifying when and how the provider may make referrals of enrollees to other practitioners.
- The PCP serves as a “gatekeeper,” determining enrollees’ access to specialty services; MCO constraints on referrals can negatively impact service delivery



Gag Clauses

- A **gag clause** is a contract provision that limits the PCP's or other clinician's ability to advise patients of all medically appropriate treatment options.



- Some gag clauses based on **moral and religious considerations** prohibit the provider from counseling patients on services the MCO objects to (e.g., abortion, contraceptive methods).

Access Standards



- These standards define the required level and availability of care from a patient-centered perspective
- Access standards in managed care contracts commonly address
 - required hours and days of operation and coverage (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
 - required intervals for providing specific services, such as well child checkups
 - maximum waiting-room times

Regulatory Penalty Provisions

- MCO contracts are frequently holding a provider liable for any fines or penalties assessed against the MCO by a state or federal regulatory agency resulting from the provider's action or inaction.
- Providers should consider whether to accept such penalties if it does not have the ability to appeal or dispute the regulatory agency's findings.



Contract Review Checklist

- ✓ **Member Verification:** Does the contract impose on the MCO the risk for errors in the MCO's eligibility verification?
- ✓ **Cost-Sharing:** Does the contract require the MCO to supply the provider with up-to-date information concerning cost-sharing?
- ✓ **Cost-Sharing:** Does the contract provide a resource for the provider to consult if it cannot determine a particular patient's cost-sharing liability?
- ✓ **All-Products Clauses:** Does the contract contain an "all products" provision, and if so, is it in the best interest of your organization?
- ✓ **Scope of Services:** Does the contract clearly define the scope of services?
- ✓ **Covered Services:** Does the contract or its attachments clearly identify the covered services available to enrollees?
- ✓ **Non-Covered Services:** Does the contract specify any requirements that the provider must meet in order to charge enrollees for non-covered services?
- ✓ **Choice of Practitioner:** Does the contract impose any limitations on which types of practitioners may provide services?

Contract Review Checklist

- ✓ **Referrals:** Are policies, procedures, protocols and timelines regarding referrals clearly spelled out in the contract or attached and incorporated by reference?
- ✓ **Referrals:** Does the contract allow the provider to determine whether and when to make referrals for specialty care or hospitalization?
- ✓ **Gag Clauses:** Does the contract impose any limitations on the provider's practitioners from advising an enrollee about the patient's health status or treatment options, the risks, benefits, and consequences of treatment or non-treatment, and the opportunity for the patient to refuse treatment or express preferences about future treatment decisions?
- ✓ **Access Standards:** Can the provider meet the access and appointment standards under its current resources and staffing?
- ✓ **Access Standards:** Is payment adequate under the contract to cover all of the costs incurred in meeting the access and appointment standards?
- ✓ **Non-Discrimination Provisions:** Is the provider's current clinical capacity sufficient to meet the increased demand that an influx of new MCO enrollees might produce?
- ✓ **Enrollee Change of Providers:** Does the contract allow the provider to transfer an enrollee to another primary care provider for cause?

Parties to the Contract

Your contract with the MCO should

- Specify the parties to the agreement
- Affirm that the provider and MCO are independent contractors
- Include a provision stating that the contract is not enforceable by third party beneficiaries



Breach and Cure

- Breaches (violation of the terms of the contract) sometimes lead to termination of the contract, but not always
- The contract should give the breaching party an opportunity to “cure” (fix) most breaches before termination is triggered



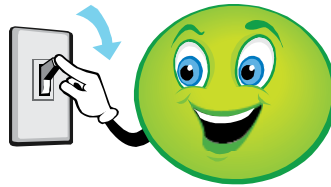
Term

- 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



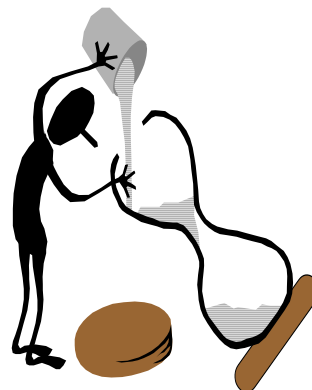
Termination

- Contracts can typically be terminated “**for cause**” or “**without cause**”
- The situations that constitute cause are generally breaches of **material terms** of the contract
- Typically either party may terminate with or without cause after providing **notice to the other party** (e.g., 30 days’ notice in terminations for cause; 60 days’ notice in terminations without cause)



Renewal

- In most contracts favorable to providers, renewal of the agreement is contingent on mutual agreement as to payment terms for the subsequent term
- The contract should specify how quickly renegotiation of payment terms must occur after one party notifies the other party of its desire to renegotiate, with a deadline for a decision



Responsibilities After Termination

- The contract should include procedures for assuring continuity of care for enrollees upon termination of the contract
- The provider should negotiate for a contract provision requiring the MCO
 - to re-assign all enrollees in the provider's panel within a specified time frame and
 - to advise members in writing of the termination of the provider' participation in the MCO



Non-Compete Clauses

- A **non-compete provision** in an MCO contract bars providers from soliciting enrollees as private patients after the contract with the MCO terminates; providers should avoid such a provision
- Preferably, the contract should provide that upon termination of the contract, enrollees have the right to disenroll from the MCO if they so choose



Assignment

- **Assignment clauses** address whether parties can transfer their rights and obligations under the contract to third parties
- Any assignment clause in the contract should be mutual: assignment by either party should be prohibited unless the other party consents



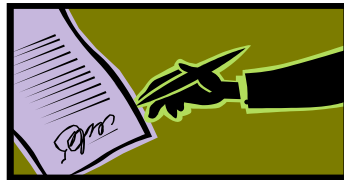
Governing Law and Venue

- The contract should
 1. identify which state's laws apply to interpretation and enforcement of the contract
 2. specify the geographic forum in which the parties can bring a legal action based on the contract



Entire Agreement

- Most contracts between MCOs and providers contain a **merger** clause stating that the contract constitutes the **entire agreement** between the parties
- This means that no other prior or subsequent understandings are legally to be considered part of the agreement, unless they are **incorporated by reference** into the contract



Amendments

- 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
 - The contract should guarantee the provider's right to **review any and all changes** to the contract
 - The contract should provide that no changes shall take effect until and unless the provider has provided prior written approval



Standard Legal Provisions Checklist

- ✓ Does the contract specify all parties and exclude those who are not parties to the contract from any rights or benefits?
- ✓ Does the contract include a provision on breach and give the breaching party an opportunity to cure?
- ✓ Is renewal of the agreement contingent on renegotiation and agreement on payment terms?
- ✓ Try to eliminate "non-compete" clauses in the contract.
- ✓ Does the contract give the provider the ability to terminate the contract if the provider does not agree to proposed amendments?

Clinical Issues



- Licensure
- Credentialing
- Accreditation
- Quality Assurance
- Utilization Management
- Insurance
- Indemnification
- Solvency
- Physician Incentive Plans

Licensure – Contract Provisions



- MCO contracts typically require that provider report any loss of licensure immediately to MCO
 - Providers should seek to avoid contract provisions that require that the provider report to the MCO whenever a clinician is in danger of losing license (e.g., under investigation by the provider); divulging information at that stage could be a liability risk for the MCO
- Failure to maintain licensure is in some contracts grounds for immediate termination
 - This is a typical provision
 - Loss of licensure by one clinician should not trigger immediate termination, so long as provider has continuing capacity to perform
 - If the contract contains such a termination provision, it should be mutual (i.e., provider may terminate if MCO loses its license)



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Credentialing

- Credentialing is the process used by MCOs to verify that a practitioner is qualified to provide services
- Includes evaluation of practitioner's education, license to practice, and certifications issued by boards in areas of specialty
- Most MCO contracts provide for credentialing at the outset of the contract and at regular intervals (e.g., every three years)
- Under Medicare and Medicaid regulations and some state insurance codes, MCOs are required to credential network providers
 - New York has "provision deeming" 90 days after submission of completed application under certain conditions



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Credentialing – Timing

- Typically, MCO credentialing must have taken effect as of the date of service in order for the provider to receive payment for services to an MCO enrollee
- MCOs typically provide a maximum timeframe for completion of credentialing (usually around 30 days), but only upon the MCO's receipt of a "complete application"
- Providers should negotiate for a definition of "complete application," if the term is not clearly defined in the contract or appendices
- Providers should review the credentialing provisions thoroughly, as problems with credentialing often prevent providers from getting paid!



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

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)



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Accreditation



- Accreditation refers to the decision of a private accrediting agency, such as the Joint Commission or the NCQA, that an institution meets standards of quality
- MCOs typically require hospitals to be accredited by the Joint Commission or the NCQA; the requirement is not extended to free-standing entities.
- If the provider has received NCQA Patient Centered Medical Home (PCMH) recognition or accreditation by the Accreditation Association for Ambulatory Health Care (AAAHC), these designations could be a basis for seeking higher reimbursement under the MCO contract



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Quality Assurance

- QA programs are an MCO self-assessment program
- Under the QA program, MCOs evaluate whether network providers' services are
 - provided in accordance with community standards of care
 - provided by health care professionals who meet the MCO's credentialing standards
 - associated with positive health outcomes for enrollees
- MCOs often contract with outside entities to perform QA evaluations



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

122

Quality Assurance – Contract Provisions



- The MCO contract should define the functions of the QA program and the extent to which the provider has input into its design and implementation, including representation on the peer review or other decision-making body
- If QA provisions in the contract (or appendices) are not clearly defined, the provider should demand that they be clarified before execution of the contract
- The provider should negotiate for **the right to review and approve**
 - **the QA standards** that will apply at the outset of the contract
 - **all amendments or other modifications to QA policies** and procedures that are implemented during the term of the contract
- The contract ideally should allocate to the MCO costs associated with the provider's implementation of QA program activities

Quality Assurance – Incentives and Sanctions

- **Sanctions:** If the MCO contract provides for sanctions for noncompliance with QA procedures:
 - the contract should require that the MCO provide written findings of noncompliance with a factual basis for such findings
 - the provider should be given the opportunity to contest the implementation of sanctions
- **Incentives:** The MCO contract may provide for bonus payments if certain quality targets are met, or may include a “quality withhold” under which payments by the MCO are withheld pending an annual determination of the provider's performance under the QA measures



Utilization Management



- Utilization management (UM), sometimes called utilization review, is the process by which an MCO decides whether specific health care services are appropriate for coverage under an enrollee's plan
- Primary purpose of the program is to ensure that services are necessary, appropriate, and cost-effective
- UM can occur at different points in the healthcare delivery cycle:
 - Prior authorization: provider must request permission from the MCO before delivering a service in order to receive payment
 - Concurrent review: occurs during an ongoing course of treatment (such as inpatient hospital admission) to ensure that such treatment remains appropriate
 - Retrospective review: review that takes place, on an individual or aggregate basis, after the service is provided



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Utilization Management – “Medical Necessity”



- The core function of the UM program is to ensure that the MCO pays for only those services that are “medically necessary”
 - Involves a determination of whether the service is necessary and appropriate for the patient's symptoms, diagnosis, and treatment
- The definition of “medically necessary” in the MCO contract is of critical importance to the provider and the enrollee
- Many MCO contract definitions of “medically necessary” state that services may not be provided primarily for the convenience of the patient or the provider



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Utilization Management – Contract Provisions

- The contract should specify all services that will be subject to UM (including prior authorization, concurrent review, and other forms of coverage determinations).
- Once agreed to by the provider, these procedures should not be subject to unilateral change by the MCO .
- The provider should negotiate for a contract provision providing that no material change in the UM policy shall take effect without the provider's prior approval.



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Utilization Management – Contract Provisions

- MCO contract provisions on prior or concurrent authorization should specify:
 - documents the provider must submit to the MCO for the review
 - special procedures for obtaining emergency authorization for services
 - the grievance / appeal procedure available to contest the denial of prior authorization (by either the enrollee or the provider on the enrollee's behalf)
 - whether under any circumstances the provider may obtain payment when the criteria for prior authorization were met, but the provider failed to timely request prior authorization.

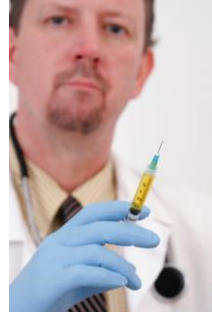


© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Utilization Management

- UM applies chiefly to diagnostic and evaluative services, hospital procedures, and certain specialty services; primary care services are **not typically subject to prior authorization or concurrent review**
- However, MCOs' UM programs are increasingly relevant to providers because:
 - MCOs often impose prior authorization or visit limits for **behavioral health services**
 - MCOs often require PCPs to seek authorization before ordering certain **laboratory tests** such as MRIs or CT scans
 - MCOs increasingly require prior authorization before a provider may **refer patients for rehabilitative services**



Insurance Requirements in MCO Contracts

- MCOs and providers negotiate managed care contracts with the objectives of managing their own risks and transferring as much risk to the other party as possible.
- Much of this transferring of risk is accomplished through insurance requirements.
- MCO contracts typically require both the MCO and the provider to carry professional liability insurance coverage, general liability coverage, and directors and officers (D & O) insurance coverage.



Provider Insurance Requirements

- The MCO contract should state clearly the forms and amounts of insurance that the provider must secure.
- Some MCOs require evidence of tail coverage; covers malpractice claims that are filed after a “claims made” policy expires, for alleged injuries that occurred while the “claims made” policy was in force.



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

MCO Insurance Coverage



- The insurance provisions in the MCO contract should be mutual.
- The MCO should be contractually required to obtain reinsurance to cover the cost of continued payment for services provided to enrollees.
- The MCO should also be required to maintain appropriate levels of comprehensive liability insurance.



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

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
- Indemnification clauses should apply to both parties
- 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



Solvency

- **Solvency** is the degree to which an entity’s current assets exceed its current liabilities
- State insurance codes typically impose solvency rules **for insurers** to ensure that the MCO can pay claims; most payor-MCO contracts include solvency requirements
- Today, because providers are increasingly assuming **risk** for the cost of services, some MCO contracts impose solvency requirements on providers
- Examples of solvency requirements:
 - Required disclosure of certain financial information (e.g. audited financial statements)
 - a requirement to maintain a specified level of reserves
 - Ratio of capital to premiums / capitation payments received
- Be sure to review any solvency requirements in the contract to determine whether the provider is able to meet them



Reinsurance

- **Reinsurance** (also called stop-loss coverage) protects providers from bearing the full responsibility of extremely costly medical services
- Two main categories of stop-loss coverage:
 - limiting provider's responsibility for expenditures exceeding a fixed dollar amount for each enrollee
 - aggregate limits of total annual expenditures for health care services furnished to all enrollees in the provider's panel
- Some MCO provider contracts require the to procure stop-loss coverage on behalf of providers; others require the provider to purchase coverage
- Providers should ensure that any stop-loss requirements are specific: the contract should specify
 - whether dollar limits are based on actual or discounted fees
 - whether only the cost of services, or also administrative costs, are counted toward the limit



Physician Incentive Plan Regulations

- Federal regulations impose reinsurance requirements on Medicare and Medicaid MCOs when the managed care contract **shifts risk to providers**
 - Such risk-shifting provisions in the contract are referred to in the regulations as “physician incentive plans”
- If a risk arrangement imposes **substantial financial risk** on providers for services that the provider **does not furnish directly, but instead orders or arranges through a referral arrangement**, the MCO must assure that the provider has stop-loss protection for the referral services
- Providers whose MCO contracts impose risk on the provider for services that will be provided through a referral should seek legal counsel to determine whether the contract provision complies with the federal rules



Contract Review Checklist

Licensing, Credentialing & Accreditation

- ✓ Does the loss of licensure of one of the provider's practitioners **not** trigger immediate termination, so long as the provider assures the MCO of its continuing capacity to perform?
- ✓ Does the contract **not** require the provider to inform the MCO if it or any of its health care practitioners are simply under investigation, before conclusive disciplinary action is decided upon?
- ✓ Does the contract define the meaning of a "complete application" for purposes of credentialing new practitioners?
- ✓ Does the contract define the amount of time the MCO has to credential new practitioners?
- ✓ Does the contract leave open the possibility of a delegated credentialing arrangement?



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Contract Review Checklist

Utilization Management/Utilization Review Provisions

- Are all UM/UR procedures, including prior and post authorization requirements, either in the body of the contract or attached to it, giving the provider an opportunity to review them prior to signing contract?
- Does the contract explicitly contain the MCO's definition of "medical necessity"?
- Does the contract give the provider notice if the MCO does not agree with the practitioner's medical opinion?
- Do changes to the M/UR procedures, including referral procedures, require notice to and an opportunity to comment by the provider?
- Is the treatment discretion of the practitioner preserved or, at a minimum, taken into account by the MCO's UM/UR Program?
- Does the MCO have clear responsibility for notifying members of any denial of a requested referral or hospital admission, with all such denials being in writing, (with a copy to the requesting physician)?
- Does the contract specify the types of services requiring prior authorization and those not requiring prior authorization?
- Does the MCO have a procedure for receiving and responding to requests for prior authorization -- 24 hours per day, 7 days per week? Make sure there are clear time limits by which the MCO must respond to a request for prior authorization, with failure to respond in a timely fashion deemed to constitute prior authorization.
- Does the contract hold the provider harmless for any legal consequences resulting from the MCO's denial of pre-authorization for requested services?



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Contract Review Checklist

Insurance Requirements

- Does the contract clearly state the forms and amounts of insurance that the provider must secure?
- If the contract requires the provider to increase its insurance coverage, has the provider negotiated for an increase in the capitation rate or fee schedule under the contract to cover this cost?
- Has the provider determined whether the malpractice insurance required under the contract is broader than the scope of the provider's current coverage?
- Does the contract require the MCO to maintain comprehensive liability insurance that will protect the provider in case of the MCO's insolvency?

Indemnification:

- Does the contract require the MCO and provider to indemnify each other with respect to their contractual responsibilities?
- Has the provider ensured that the indemnity requirements that apply to the provider do not include conduct outside its control?
- Does the contract require the MCO to indemnify the provider for consequences of the MCO's improper denial of prior authorization for a service?



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

Concluding Thoughts

- Adopt (and invest) in **medical home** model
 - Attain Highest-Level Recognition Possible
 - Obtain Meaningful Use Incentive Payments
- Pursue **collaborations** with local providers and provider networks to integrate care
 - But carefully analyze:
 - Potential risks and rewards
 - Financial incentives for each party
- Engage payors about **new payment approaches** that support and reward the value of your services



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

140

Questions?

Adam J. Falcone
afalcone@ftlf.com

Feldesman Tucker Leifer Fidell LLP
1129 20th Street, NW – 4th Floor
Washington, DC 20036
(202) 466-8960
www.ftlf.com



© Feldesman Tucker Leifer Fidell LLP. All rights reserved.

www.FTLF.com

141