KEY ISSUES IN MANAGED CARE CONTRACTING

Presented by:
T. Daniel Hollaway

EXTERNAL FORCES IMPACTING MCAs

- Multiple Sources of health plan
  funding and regulation
- Claim Administration Processes vary greatly with plans
- Patients
- Funding Issues of Employers
- Public and Private Interests demanding transparency; more and better care for the same or less money

Principal Causes of Provider Disputes

- Contracting parties with different objectives
- Payor agenda is to minimize costs and maximize access
- Providers want to maximize reimbursement and limit the number of competing Providers.

Contributing Factors to Provider Disputes

- Patient (Member) eligibility and coverage issues are governed by separate agreements that may conflict with the Provider's MCA.
- Lack of uniformity in coding and reimbursement policies and procedures
- Lack of uniformity in application of clinical criteria

An incongruent aspect of the MCA process:

- Attorneys are not generally not involved in contract negotiations.
- Misunderstandings and misinterpretations may not be addressed during the negotiation process.
- Contract negotiators may be reluctant to confront difficult issues during negotiations.

Plan of Action for MCA Process

- Reconcile health plan regulation with the managed care contracting process.
- Preserve the right of the Provider to enforce contract via administrative and legal remedies
- Carefully consider terms for dispute resolution (one size does not fit all)

A Common Misconception:

- The contract format presented by MCO or Insurer has been approved by the state's regulators, so our legal department will not let us make any changes.
- If we make any changes, it take a very long time to get them reviewed and approved.

Reality:

- Most MCAs are not filed with or reviewed by state regulators.
- Few provisions, if any, in a MCA are required by state or federal law, such as "hold harmless" laws.
- Most other contract provisions, with few exceptions, are negotiable.

Goal of Contract

- To clearly, and without ambiguity or vagueness, express the exact and complete agreement of the parties.

Enforceable Contract:

- An offer
- An acceptance
- Mutual Assent (who is and is not assenting?)
- Execution and delivery of contract with intent it be mutual and binding
- Consideration given by the parties.

THE NUMBER ONE ENEMY OF ENFORCEABILITY OF MOST MANAGED CARE AGREEMENTS IS…

AMBIGUITY

BASIC ELEMENTS OF A MCA
(PAGE 1)

- Who are the Parties?
- What are the definitions being used?
- What Product(s) and/or Plan(s)?
- What services will be provided?
- Who is legally obligated to pay?
- How much will Provider be paid?

BASIC ELEMENTS OF MCA
(PAGE 2)

- Billing Requirements
- Payment Procedures
- Payment Obligation (whose obligation?)
- Time Frames
- Applicability of State and/or Federal Law

BASIC ELEMENTS OF MCA
(PAGE 3)

- Utilization Management
- Referrals
- Authorizations
- Access to Financial Information (Is it Mutual?)
- Access to contract by Payors

BASIC ELEMENTS OF MCA
(PAGE 4)

- Recoupments, Refunds & Offsets
- Term and Termination
- Indemnification Issues
- Notice Provisions
- Confidentiality Provisions
- Fed and State Requirements, *e.g.*, Medicaid, SCHIP, MA, HIPAA

DEFINITIONS WITHIN A MANAGED CARE AGREEMENT ARE SIGNIFICANT.

DEFINED TERMS ARE "OPERATIVE TERMS".

MCA TERMS THAT MUST BE CLEARLY STATED AND DEFINED

- How & where to get authorizations
- Parties responsible for referrals and auths
- Clean Claim
- How/Where to Bill
- Penalty Clause
- Notice Provisions
- Identity of Parties
- Patient Population
- Type of Plan(s)
- Scope of Services
- Entity that Pays
- Governing Law(s)
- Groups and Entities with Access to the Contract

EXAMPLES OF AMBIGUOUS TERMS

- "Plan or Payor"
- Network Lessee
- Network Affiliate
- Plan Designee
- Reasonable and Customary
- Best Efforts
- Within a reasonable time frame
- As applicable…
- As determined by…
- Complete and Proper
- Accurate and Complete

PRE-SIGNING CONSIDERATIONS

- Financial Statements?
- Checked on Complaint Records at State Ins. Dept?, USDOL, etc…
- Reinsurance in force for insured books of business?
- Litigation? If yes, who and why?
- Have other Provider's termed their contracts?
- Financial Viability of Payor(s)
- Single Product or Multiple Product Contract?
- How many lives? Any real steerage to my practice/hospital here?
- Are Excess Loss insurers covering Payors or Plans that will access MCA?
- Insolvency insurance an issue?

OTHER ITEMS TO CONSIDER BEFORE SIGNING OR RENEWING

- All UR/UM criteria, policies and procedures
- All "Policies", Guidelines" "Manuals", etc., or other documents that are "incorporated by reference" into the contract—including what is posted via Internet
- Insist on having the opportunity to review and reject any amendments to <u>anything</u> that affects UR/UM, billing or payment (See: 28 TAC § 11.901)

Prohibit Unilateral Amendment of Payment Terms

28 TAC § 11.901(c)4)

No amendment, revision, or substitution of any of the claims payment procedures or any of the information required to be provided by this subsection will be effective as to the contracting physician or provider, unless the HMO provides at least 90-calendar-days written notice to the contracting physician or provider identifying with specificity the amendment, revision, or substitution. An HMO may not make retroactive changes to claims payment procedures or any of the information required to be provided by this subsection. Where a contract specifies mutual agreement of the parties as the sole mechanism for requiring amendment, revision, or substitution of the information required by this subsection, the written notice specified in this section does not supersede the requirement for mutual agreement.

AREAS OF PARTICULAR CONCERN IN MCAs

- Conflicts in definitions; whose definitions control?
- Excessive levels of administrative appeal
- Adjustment and Refund Provisions

AREAS OF PARTICULAR CONCERN IN MCAs

- Utilization Management Decisions
- Retrospective Decision-Making…(who has the discretion?)
- What and where are the controlling clinical criteria?
- Does contract require disclosure?

AREAS OF PARTICULAR CONCERN IN MCAs

- Assignment of Benefits: Acceptance of Provider's Assignment needs to be contractually provided to avoid effect of anti-assignment clauses.
- Alternative protection is inclusion of intended third-party beneficiary language.
- Require that Payors acknowledge terms of Provider's agreement in writing and that Provider be able to obtain copies.

ADDITIONAL TERMS TO CONSIDER

- Stop Loss Provision: Threshold amount based on billed charges or other readily determinable threshold.
- Notification of Emergency Admits: Within 24 hours or next business day, not next working day
- Plan's availability of UR team should be reflected in Provider's obligation to obtain authorizations
- No penalty for failure of PCP to give referral if services are authorized.

Multiple Payor Access

- If multiple Payors will have access to the Provider via the MCA, the contract should include the right to terminate a specific Payor for non-compliance with the terms of the MCA.
- This right of selective termination of a non-compliant Payor should be reserved to the discretion of the Provider in lieu of complete termination of the contract.

“All products” provisions in MCAs (p.1)

- Significant for physicians
- Becoming more significant for hospitals
- High-Deductible health plans and Limited Benefit policies will require special analysis
- Addition of any “new products” should require express mutual agreement.

“All products” provisions in MCAs (p.2)

- OK to include high deductible health plans if MCA states the deductible limits for a product to be included as an eligible product
- Require that high deduct plan be linked to a Health Savings Account (HSA) at time of registration (OP); or at admission (IP)
- Require ability to verify 24/7 amount of deductible and whether it has been met

ALTERNATIVE DISPUTE RESOLUTION VERSUS LITIGATION IN THE COURTS

ADR TECHNIQUES	LEGAL ACTION
Notice	Notice
Meetings	Meetings
Mediation	Pre-suit notice
Arbitration	Service of Process

ARBITRATION OR NOT?

PROS

- Not "real" litigation
- Proceedings not public
- Parties sometimes feel less threatened by arbitration and mediation
- Prevailing party can sometimes recover its legal fees and court costs
- Can be planned for in contract

CONS

- Lacks the leverage of lawsuits
- No Court to enforce disclosure of documents
- Often costs as much or more than lawsuits in the public courts
- Often takes as long as lawsuits—scheduling issues with panels of 3 arbitrators
- May have to file suit anyway to enforce an arbitration award or appeal.

MCA CHECKLISTS

Everyone has them, but all deals are different…

No single "cheat sheet" is perfect

MCA Checklist (p.1)

- Make you have sure the correct entities named.
- Make certain that the agreement may not be unilaterally amended by either party, nor unilaterally assumed by a successor through sale or merger

MCA Checklist (p.2)

- Make certain all administrative procedures and provider manuals are in hand, (and included in the legal review of the proposed agreement), in advance of the effective date of the contract
- Verify that the Provider and Payor can administer the utilization management, billing and payment requirements of the agreement, esp. carve-outs, outlier or other special arrangements

MCA Checklist (p.3)

- Make certain that the bases for termination with cause are specific, *i.e.*, what conduct shall constitute non-performance, default and material breach.

- Pay special attention to words and phrases that are operative terms. Are there any operative terms that appear repeatedly, but which lack a specific definition?

MCA Checklist (p.4)

- Make certain that the definitions in MCA will control in the event of conflict between terms and definitions in benefits plan certificates, policies or other descriptions of coverage provided by a Insurer, Payor or Employer

- Do not subordinate YOUR agreement to that of another which may contain definitions and terms that differ from your MCA.

MCA Checklist (p.5)

- Make certain that the Provider has standing to assert all administrative appeals and legal remedies available to enforce the contract
- Require the Payor or Plan to notify the Provider of all legal actions brought against it involving claim administration and claim payment, including ADR filings
- Check public records regularly for complaints, investigations, fines and other disciplinary sanctions

MCA Checklist (p.6)

- Make certain billing procedures are set forth in sufficient detail, including a method for determining payer's "Date of Receipt" of a claim.
- Definition of "Payment", *e.g.*, the date that payment is received via EFT, lock box or via physical delivery to Provider's facility.
- Note: The Tex. Admin Code is not in your contract unless you affirmatively incorporate desired provisions.

MCA Checklist (p.7)

- An Insurer or a Payor customarily has a right to audit. Provider should also require a similar right to retrospectively audit the claim adjudication and payment practices of the payer for contract compliance. Insurers and Payors should agree to cooperate with requests for data.

- The exact address to send official notices and the method, e.g. certified mail, should be included. Consider requiring notice to the appropriate person or department within administration **and** that the agreement also provide that all such notices be simultaneously served on the provider's legal counsel.

MCA Checklist (p.8)

- Confidentiality is important.

- State with specificity that violation of the confidentiality terms is grounds for termination and a claim for damages.

MCA Checklist (p.9)

- Insurer or Payor’s rights to effect refunds should be limited in terms of time, *e.g.*, no recouping payments previously made more than six months after Provider’s receipt of payment. (Suggestion: track Tx Admin Code provisions as contractual terms.)

- Providers should have a complementary obligation to file claims and initiate administrative appeals in a timely manner, *e.g.*, claims filing within 95 days and appeals initiated within 180 days from receipt of explanation of benefits or remittance advice denying a claim, in whole or in part. (TAC provides acceptable time frames).

MCA Checklist (p.10)

All products and plans having access to the agreement must be specified. No unilateral addition of plans or payers. No "leasing" of the network without the Provider's express consent.

Unauthorized leasing of network access should be described as a material breach, subject to immediate termination and a claim for liquidated damages.

MCA Checklist (p.11)

- Include an enforceable prompt payment clause as a contractual obligation.

- To be of any significant benefit to the Provider, a "prompt pay" clause must be included as a contractual obligation of the Payor.

- Don't forget to state the penalty.

MCA Checklist (p.12)

- Consider carefully whether to agree to binding arbitration. Surrendering the right to obtain relief in the Courts should not be done hastily. Is there adequate consideration being given for that concession?

MULTIPLE SOURCES OF HEALTH PLAN REGULATION

- Self-Insured Plans-Private Sector (Federal & State)
- Group Health Plans-Governmental Employees (Federal & State)
- Individual Insurance Policies (State)

Medicare (Federal)

Medicaid (Federal & State)

Managed Medicare (HMO) (Federal & State)

Managed Medicaid (HMO) (Federal & State)

Veterans Benefits/TRICARE (Federal)

Longshoremen and Harbor Workers (Federal)

Jones Act (Sailors and Seamen) (Federal)

FEHBA (Federal Employees) (Union/Non-Union)

Third-Party Liability (State Law and MSP Rules)

CHAMPUS Benefits (Federal)

State Worker Plans

Railroad Retirees (Federal)

Workers Compensation (State and Federal)

FEDERAL WORKERS' COMPENSATION

- Federal Employees under OWCP
- No state law remedy
- Appeal to Office of Personnel Management
- Further Appeals to US District Court

PRIVATE SECTOR EMPLOYEES

- Covered by Employee Retirement Income Security Act (E R I S A)
- Must exhaust admin appeal before can sue
- Some state insurance laws will not apply, even if a group insurance policy is the funding source
- No punitive damages

What is a Clean Claim?

- Defined by Contract
- Defined by Regulation and Agency Rules

What is a Clean Claim?

- Data elements - see Tex. Admin Code
- Rule §21.2803
    - CMS 1500
    - UB 04
- Attachments
- Additional clean claim elements
- Format
    - Legible, accurate, complete
    - ***Too much information does not render an otherwise clean claim deficient.***

Clean Claim Rules – Texas Law

- An insurer must act on clean claims within 45-day statutory claims processing period.
- Pay the claim, in total, in accordance with contract.
- Pay portion and deny portion, and notify physician or provider in writing of reason for denial.
- Pay (or deny) portion and audit portion, notify physician or provider in writing that claim is being audited, and pay 85% of the contracted rate on the audited portion.
- Audit entire claim, notify physician or provider in writing that claim is being audited, and pay 85% of the contracted rate.
- Deny the claim in total and notify the physician or provider in writing of the reason for denial.

Proof of Claims Submission

- Claims mail log
- Presumed to be received on the third business day after the date the claim is mailed and the faxed or electronically generated log is transmitted
- Return receipt
- Electronic confirmation
- Fax confirmation
- Presumed to be received on the the date of signed receipt or electronic/fax confirmation

Clean Claim Rules – ERISA

- POST-SERVICE CLAIMS
- Federal Regulations require the Plan to notify the claimant of any adverse decision within 30 days
- Plan may have a 15-day extension if notice of the necessity and reason is given within the 30 day time frame
- ERISA provide no late payment penalty; however, that can be remedied by contract

AUDIT RULES

- Prior to seeking a refund for a payment made under this section, an HMO or preferred provider carrier must provide a preferred provider with the opportunity to appeal the request for a refund in accordance with 28 TAC §21.2818.
- An HMO or preferred provider carrier may not seek to recover the refund until all of the preferred provider's internal appeal rights under §21.2818 of this title have been exhausted.
- Note: Consider importing same or similar terms into contracts to apply to all Payor categories

Date of Claim Payment

A claim is considered to have been "paid" on the date of:

- U.S. Postal Service postmark
- Electronic transmission
- Delivery of the claim payment to a commercial carrier, such as UPS or Federal Express, or
- Receipt by the physician or provider, if a claim payment is made other than provided above

Provider Lawsuits

- Breach of Contract
- Violation of Implied Duty of Good Faith and Fair Dealing
- RICO Violations
- Violation of State Prompt Pay Laws
- Common Law Fraud and Misrepresentations
- Unjust Enrichment

Baylor v. Arkansas Blue Cross Blue Shield, 331 F.Supp.2d 502 (N.D. Tex. 2004)

- Facts: Lawsuit by medical center against Health Plan (Ark. BCBS).
- Claims: Breach of contract and violates Texas Prompt Pay Law
- Issue: Is the hospital's state law claim for breach of contract preempted by the federal ERISA?

Baylor v. Arkansas Blue Cross Blue Shield

- Holding: State law claims not pre-empted by ERISA
- Basis: Two prong test
  - Contract claims not dependent on or derived from insured's rights to benefits under an ERISA Plan
  - Contract claims do not impact relationship between Plan and its beneficiaries

Prompt Payment: Medicare Advantage

- Preemption applies to Medicare managed care plans if state law is:
  - inconsistent with CMS MA rules
  - benefits requirements
  - requirements re inclusion/treatment of
  - providers
  - coverage determinations, including appeals and grievances

Prompt Payment: Medicare Advantage

- MMA significantly expanded preemption of state laws applicable to Medicare managed care plans
- Medicare Advantage requirements supersede all state laws and regulations re Medicare Advantage plans, except those relating to licensure and plan solvency

Prompt Payment: Medicare Advantage

Contracts or other written agreements between Medicare Advantage organizations and providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the Medicare Advantage organization and the relevant provider (42 CFR § 422.520(b); OPL 2000.077)

Prompt Payment: Medicare Advantage

- Contracts between CMS and Medicare Advantage organization:
  "All other claims" (non-PFFS and other than non-contracted providers) must be paid or denied within 60 calendar days from date of request
  (42 CFR § 422.520(a)(3)).

Prompt Payment: Medicare Advantage

- Provider perspective: Awareness of lines of business, i.e., MA, covered by contract;
- Specify that prompt payment provision applies to all plan enrollees
- Plan perspective: Medicare Advantage compliance; Consistency of operations

Get it in the contract!

Prompt Payment: ERISA Plans "Self-Insured" Enrollees/Patients

- Prompt payment laws otherwise applicable to MCO as health plan do not apply to MCO as administrator of self-insured plans.
- Examples of other state laws not applicable:
  – hold harmless
  – contract termination
  – member appeals
  – continuity of care

Prompt Payment: Self-insured enrollees/patients

- Provider perspective—Awareness of lines of business, i.e., self-funded programs, covered by contract

- Specify that a prompt payment provision applies to all plan enrollees

Prompt Pay Laws: APPLICATION OF HIPAA

- HIPAA transactions and code set rules established electronic standards for specified transactions, including claims payment (45 CFR Part 162)
- No timeframes specified
- Covered Entities must comply
- Hospitals are Covered Entities

Prompt Pay Laws: APPLICATION OF HIPAA

- HIPAA trading partner agreements may not change definitions, data conditions or data elements in HIPAA standards, add data elements not required by HIPAA

What about time frames for legal action?

General Rule:

If Provider has not received payment within 45 days of an electronically submitted claim or 90 days for a paper claim, investigation is warranted.

This general rule of "45 days electronic/90 days paper" is based on the deadlines which apply to most financial classes of claims.

Also consider the face amount of the claim and whether there are other claims involving the same issue or same payer.

Time Frames and Deadlines

- 60 days from date on RA for managed Medicare Advantage plans
- 120 days from date on RA for managed Medicaid (Star and Star+Plus)
- 120 days for retro audits by TMHP or traditional Medicaid.

Time Frames and Deadlines

- 60 – 180 days MAXIMUM for most commercial business.
- Can be less due to many health plans being exempt from state law.
- Federal law (ERISA) permits the appeal deadline to be set anywhere from 60 -180 days, at the employer's discretion.

Commercial Group Insurance Products

- HMO: 60 days from EOB
- PPO: 60 days from EOB
- Because ERISA dictates the general rule for employer-sponsored commercial HMO/PPO/PPO/EPO business, the only safe option is to assume a 60-day deadline to challenge a denial.
- Reconcile MCAs to the law based on the product and population being serviced.

A COMMENT ABOUT ADMINISTRATIVE APPEALS

Most group health plans provide for some form of administrative review of denial or underpayment.

The ***written record*** of that review may be the only information reviewed by the Court in later litigation, so it needs to be well presented and persuasive.

General Statutes of Limitation

- 1 year for Texas Workers' Comp Claims or per WC Network Contract
- 2 years for misrepresentation and other business torts
- 4 years for breach of contract
- Note: Health Plans, Insurance Policies and Providers' MCAs may contain other and shorter deadlines imposed by contract or by agency regulation.

How does a Provider enforce its rights?

- Secure enforceable obligation via contract.
- Rely on Assignment from patient.
- Rely on state law and common law.
- Rely on Regulatory Agencies.

- Know your contracts and how they really work.
- Know your time lines to take action for the different kinds of health plans.
- Know your legal remedies and when to use them.

I humbly suggest…

- Have all managed care agreements carefully reviewed by consultants or legal counsel that have experience enforcing them.

- There is always room for negotiation and improvement.

Thank you!

HOLLAWAY & GUMBERT

www.healthlawtexas.com

If you would like more information about our health law practice, please contact T. Daniel Hollaway at 713.942.7900 or by email: dhollaway@houstonlaw.com