



Medicare Advantage Toolkit

Module III: Key Contract Components – Model Contract

About the Authors

Mark E. Reagan

Mr. Reagan is the managing partner and head litigator of the San Francisco office of Hooper, Lundy & Bookman, P.C., the largest full service law practice in the country dedicated solely to the representation of health care providers. He received his B.A. degree in Economics and Communication from Stanford University in 1983. In 1989, he received his J.D. from Loyola Law School, Loyola Marymount University and was admitted to the California Bar that same year.

Throughout his legal career, he has represented long term care facilities, hospitals, physician groups, home health agencies, hospices, medical product suppliers, trade associations, and other health-related entities in California and in numerous other states. His practice is devoted to counseling, litigation and trial and appellate work, before administrative agencies and all courts, with an emphasis on health care issues, including long term care, managed care, health care fraud and elder abuse, licensing and certification, Medicare and Medicaid, false claims, anti-trust, unfair competition, workers' compensation reimbursement, risk management and corporate compliance. He frequently testifies before the California State Legislature on these and other health related matters and assists clients with legislation and regulatory enactments.

Mr. Reagan serves as General Counsel to the California Association of Health Facilities, the largest trade association primarily serving the long-term care profession in California. He serves on the Legal Committee for the American Health Care Association, and was the chair of that group from 2006 through 2009. Mr. Reagan is a board member of the American Board of Medical Quality.

He has also handled several false claims cases to successful conclusions, including *U.S. ex rel. Swan v. Covenant Care, Inc.*, 279 F.Supp.2d 1212, 1217 (E.D. Cal. 2002), in which the Court held that regulatory violations and other "quality of care" concerns cannot give rise to false claims liability as to skilled nursing facilities participating in the Medicare program. Mr. Reagan has had a number of published decisions throughout his career within the California appellate courts and Supreme Court as well as the United States District Courts and the Ninth Circuit Court of Appeals.

Mr. Reagan is also a nationally recognized speaker, instructor and author on health related topics.

Jim Miles

Jim Miles is an attorney with the Denver and Phoenix offices of Miles & Peters, a firm that has a national practice specializing in health law. Mr. Miles has been practicing health law for 18 years. He specializes in the representation of health care providers, emphasizing business planning, commercial transactions, Stark and Anti-Kickback compliance, and joint ventures. His clients include hospitals, physician groups, nursing homes, assisted living facilities, community health centers, ambulatory surgery centers, clinical labs, and all other provider types. His clients also include managed care organizations (MCOs), accountable care organizations (ACOs), and independent practice associations (IPAs).

He serves as outside general counsel to several health care provider trade associations, including Colorado Health Care Association, Arizona Health Care Association, Wyoming Health Care Association, Colorado Community Health Network, and Community Health Association of Mountain and Plains States.

Mr. Miles served as a Vice Chair of the American Health Lawyers Association from 2004 through 2007. He was also selected as one of the top health lawyers in the United States by his peers in two publications, *Super Lawyers* and *Best Lawyers*, for years 2009 through 2014. He also is currently the Vice President of the Executive Council of the Colorado Bar Association's Health Law Section.

Mr. Miles has been actively involved in advising clients regarding health care reform initiatives. He specializes in legal and strategic planning for ACOs, bundled payment initiatives, risk-based contracting, value-based payments, physician integration, managed care contracting, and other related initiatives.

Module III: Key Contract Components

This document is not intended as legal advice and should not be used as or relied upon as legal advice. It is provided for general information purposes only and may not be substituted for legal advice. Specific legal advice is crucial when preparing for or negotiating an important contract that would have significant financial and legal consequences: **ALWAYS SEEK THE ADVICE OF KNOWLEDGEABLE COUNSEL TO PROVIDE ADVICE THAT IS TAILORED TO THE ACTUAL FACTS AND CIRCUMSTANCES AND TAKES INTO ACCOUNT ALL RELEVANT LAW.**

About This Module

This Module is designed to assist skilled nursing centers with evaluating the key terms of MA plan contracts. It identifies and describes the key contract clauses, in many instances providing examples of language that is more favorable for skilled nursing centers, language that is more favorable for MA plans, and language that is neutral. Accordingly, this Module may serve as a free-standing educational tool, and it also may be utilized as a checklist during a side-by-side review of a contract proposed by a MA plan.

An MA plan contract may appear to be a lengthy, boring, document that is replete with legalese and seemingly general provisions. However, usually because of their general-sounding nature, such terms often give the MA plan the ability to exert control and power over key deal terms. Often, it is not what is included in the MA plan contract that is harmful, but rather what is missing. Such missing terms, once added, can create a more balanced contract that is fair to both parties. Of course, a skilled nursing center's ultimate ability to change the MA plan's standard template contract is usually a function of leverage – how important is the skilled nursing center to the MA plan. A skilled nursing center that is an attractive partner to an MA plan may have sufficient leverage to successfully negotiate contract changes. Examples of possibly attractive skilled nursing centers include (1) those the MA plan needs to meet its network adequacy requirements,¹ (2) those that have a specialized clinical program not available in the same geographic market (e.g., behavioral, stroke rehabilitation, traumatic brain injury, etc.), and (3) those that can help an MA plan achieve better “bonus” payments from Medicare as described in the preceding Module. On the other hand, skilled nursing centers that have not been identified as attractive partners, or skilled nursing centers that seek to contract with a MA plan in a geographic area where the MA plan has sufficient post-acute care provider network adequacy, may find that their requests to modify the MA plan's contract are rejected or ignored.

¹ CMS has established MA plan provider “network adequacy” criteria that include three components: (1) minimum provider-to-enrollee ratio; (2) maximum travel distance to providers; and (3) maximum travel time to providers. For a detailed explanation of MA plan network adequacy requirements, see the CY 2014 “HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance” located at <http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps>.

Regardless of the leverage that exists, it is paramount that skilled nursing centers understand the key contract terms in each MA plan contract described below.

Pre-Contractual Issues

Before addressing key contractual provisions, it is worth noting that skilled nursing centers must endure pre-contractual processes that may be time consuming. MA plan “credentialing” processes may require the preparation and provision of a variety of reports to the MA plan identifying the skilled nursing center’s hospital readmission rates, average length of stay for Medicare Part A patients, staffing ratios, Five-Star Quality Ratings, recent health department survey history, and other data. Most MA plans conduct site visits at the skilled nursing center as a prerequisite to contracting, and a few MA plans require private accreditation by a third party accreditation organization such as The Joint Commission. Skilled nursing centers should also anticipate that current RN staffing levels may change as a result of needing more RN FTEs to interact directly with MA plan case managers, obtain prior authorizations, and monitor utilization patterns. Many providers entering into MA plan contracts find it necessary to hire one or more RNs who understand managed care systems.

Rate Methodologies and Covered Services

Typically, MA plans structure their skilled nursing center rates in one of two ways. Geography appears to be the single-largest factor in determining which method is used. The first method involves paying a percentage of CMS fee-for-service, per diem, published rates. For standard inpatient skilled nursing services, the MA plans pay a percentage of the applicable Medicare Part A Prospective Payment System Resource Utilization Group (“RUG”) per diem (*e.g.*, X% of the CMS RUG rate). While the percentages are of course the subject of negotiation with the MA plan, they typically range from 80-100% of the CMS published rates. Likewise, for Medicare-covered services during a non-skilled stay, such as therapy services, the MA plans using this method pay a similar percentage of the applicable Medicare Part B published rate.

The second method involves paying by “levels” (sometimes referred to as “tiers”) according to the MA plan’s own per diem fee schedule rather than the CMS fee-for-service published fee schedule. The “levels” are described in the MA plan contract or the MA plan’s payment policies that are incorporated by reference into the contract. Like RUGs, the “levels” are acuity-based and attempt to account for the intensity of care services required by a particular patient. The “levels” are typically divided into four or five categories, with the higher per diem payments for higher “levels.” Despite the existence of different “levels” in the contract, skilled nursing centers often find it difficult to convince MA plans that patients are appropriately placed in the higher “levels.” This factor, coupled with potential lag times between submissions of claims and payment of per diem rates, which usually are longer than Medicare fee-for-service lag times, places greater importance on ensuring that per diem rates for lower and middle “levels” are as high as possible.

With both rate structures, there is an increase in the use of risk-based payment concepts as part of the rate methodology. MA plans may compensate skilled nursing centers in a manner that

requires the skilled nursing centers to accept some financial risk. Examples of risk-based payment models include: (1) the payment of fixed fees for certain episodes of care (also referred to as “bundled payments”); (2) ascribing a certain amount of reimbursement to patient outcomes, quality indicators, patient satisfaction surveys, and/or similar value-based concepts; (3) capitation models, where skilled nursing centers are paid a fixed fee “per member per month;” and (4) “shared savings” programs. Under “shared savings” programs, the parties establish a base year for specific metrics like total costs of care, readmission rates, and lengths of stay. If such metrics improve in future years versus the base year, the provider is paid a shared savings incentive payment in addition to RUGs or “levels” per diem rates. If the contract calls for any risk-based payment method, the contract essentially shifts financial risk to the skilled nursing center. If entering into a contract with risk-based payment structures, a skilled nursing center should: (a) develop a strong understanding of the covered services included within the risk-based payment; (b) if possible, make financial projections regarding the amount of reimbursement under the proposed risk-based payment structure; and (c) ascertain enrollee utilization rates, demographics, and acuity trends to determine whether the acceptance of financial risk could become too great over the contract term.

Under either rate structure, but especially with the “levels” method, skilled nursing centers should pay close attention to the list of “carve-outs,” meaning certain types of patients that are excluded and reimbursed separately using per diem rates that exceed the general RUGs or “levels” per diem rates. Examples of typical carve-outs include “outlier” patients who are:

- Bariatric (*e.g.*, those who weigh over 300 pounds or who have a particular body mass index);
- Younger in age (*e.g.*, less than 40 years old);
- Convicted sex-offenders who will require isolation; or
- Diagnosed with particular conditions or injuries, such as traumatic brain injury, prior history of drug addiction, extreme combativeness, or dementia.

Skilled nursing facilities should also ensure that “carve-outs” include items and services that have significant acquisition costs. Such “carve-outs” allow the skilled nursing center to receive the applicable RUG or “level” per diem rate for skilled nursing care but also allow the skilled nursing center to charge the MA plan additionally for higher cost items, such as certain pharmaceuticals (*e.g.*, experimental antibiotics, colony stimulating factors, IV therapy, AIDS medications, etc.), special durable medical equipment, and special adaptive equipment. Items and services that most MA plans expect to be included in the RUG or “level” per diem are room and board, nursing care, routine imaging services like x-ray, routine medical supplies, enteral nutrition services, routine labs, standard durable medical equipment, and oxygen services. Some “carve-outs” can be structured as “stop loss” provisions, meaning that the skilled nursing center is at risk for absorbing costs up to a certain agreed-upon ceiling for each patient.

The failure to specifically include special reimbursement for “carve-outs” in the contract can be very problematic for skilled nursing centers, especially because the state and federal governments typically mandate that skilled nursing centers are responsible for providing such services. Skilled nursing centers must continue to meet state and federal laws regarding required services regardless what the MA plan contract states. State health departments and CMS will

continue to survey the skilled nursing center for substantial compliance with state and federal laws, so they must ensure that all such services are defined as “covered services” in the managed care contract. “Covered services” language, which may appear in a separate section of the contract than the rates language or fee schedule, should interface with, rather than conflict with, the contract’s rate methodology.

Sample Language for Covered Services:

Favorable Definition: Covered Services means those healthcare services, equipment, and supplies that are required by federal law to be covered under a Member’s Benefit Program. The Provider shall be entitled to provide all Covered Services for which it is licensed and required to provide under applicable laws.

Unfavorable Definition: Covered Services means those healthcare services, equipment, and supplies that are covered under a Member’s Benefit Program as determined by the MA plan from time to time. Updates to Covered Services will be posted on our provider web portal.

Essentially, a skilled nursing center should attempt to (1) ensure that all legally required services are included within a contractual definition of “covered services,” and (2) obtain appropriate “carve-outs” that allow the skilled nursing center to provide such services without assuming undue financial risk.

Utilization Review

Utilization Review (“UR”) generally describes an MA plan’s process to determine whether its healthcare services are medically necessary and appropriate for enrollees. It is a central element of managed care and therefore an important component to the managed care contract. Generally, an MA plan’s UR program is designed to evaluate healthcare on the basis of appropriateness, necessity, and quality. An MA plan may require prior authorization before a provider delivers certain services to an enrollee and may not pay for the services if those services are not authorized. An MA plan may also conduct “concurrent review” at certain length of stay benchmarks (*e.g.*, 14 days, 21 days, etc.), or “retrospective review” after completion of services, to determine whether it believes continued or historic skilled nursing care is appropriate and medically necessary.

Even in situations where the MA plan has issued a prior authorization for certain services, the MA plan nonetheless may still conduct a “retrospective review” and attempt to recoup payments for already adjudicated / processed claims if it believes that the prior-authorized services did not meet medical necessity criteria. Just as original Medicare conducts post-payment claims reviews through various audit processes, so do MA plans. A skilled nursing center should not presume that the existence of a prior authorization insulates it against further scrutiny. Skilled nursing centers that enter into contracts with MA plans must, therefore, be prepared to produce documentation to support medical necessity and the validity of the previously issued prior authorization. Skilled nursing centers must have adequate systems to track “retrospective review” requests, calendar deadlines to respond and appeal, and record documentation provided in response to such requests. Ideally, such systems will include internal chart review by a clinician familiar with the MA plan’s medical necessity criteria, with such internal review

occurring before the response is submitted. Depending on the complexity of the prior authorization process and the number of charts subject to “retrospective review,” a skilled nursing center could have to increase its staffing levels for clinicians and clerical / medical records staff.

Although MA plans focus greatly on average length of stay (“ALOS” or “LOS”) for skilled nursing patients under the per diem rate structures, the authors have never encountered an MA plan contract that expressly imposed LOS caps, either generally or by diagnosis. Indeed, it would be hazardous for an MA plan to do so given the civil liability risks that could follow. However, the MA plans typically do informally impose LOS caps through prior authorizations, concurrent review, steering patients to in-network skilled nursing centers with lower LOS, and “panel reduction” (*i.e.*, declining to renew, or terminating, MA plan contracts with providers who have higher LOS). Additionally, some MA plans have adopted “network normalization” programs, through which they attempt to develop LOS metrics acceptable to the MA plan by diagnosis, episode of care, co-morbidities, etc. When challenged by skilled nursing centers to cite specific contractual provisions that allow the MA plan to compel discharge or reduce the level of care, the MA plan will generally cite to the general UR provisions in the contract.

Sample Language Regarding the UR Program, in General:

Favorable Language: The Provider agrees to participate in and cooperate with the UR Program utilized by the MA plan, subject to the Provider’s right to appeal any adverse decisions on behalf of itself or as an authorized agent on behalf of the Member. A copy of the MA plan’s UR Program is attached to this Agreement as Exhibit ____.

Unfavorable Language: As a condition for payment for Covered Services, the Provider agrees to participate in and comply with the MA plan’s UR Program, as amended by the MA plan from time to time in its sole discretion, utilized by the MA plan to promote the efficient use of resources. The Provider shall comply with and shall be bound by such UR Program. If there is a conflict between Provider’s utilization review standards and the MA plan’s standards, for purposes of this Agreement, the decision of the MA plan’s Medical Director, or his or her designee, shall control.

It is important, therefore, for skilled nursing centers to clearly document any UR decisions made by the MA plan in case the patient suffers an adverse outcome that leads to an investigation or civil litigation. Skilled nursing centers should understand, however, that, even though an MA plan makes a medical necessity or coverage determination, the decision whether a patient is appropriate for discharge or a reduced level of care is legally the skilled nursing center’s decision. In a situation where the MA plan denies coverage for a specific LOS and the skilled nursing facility believes that it should continue to care for the patient, the skilled nursing facility should continue care and avail itself of the MA plan contract’s UR appeal system.

In order to review an MA plan’s UR program, skilled nursing centers will have to ensure that they receive the UR program information in its entirety. If a contract refers to the MA plan’s UR program only by incorporating by reference the MA plan’s policies, procedures, and manuals

that address its UR program, the skilled nursing center should request and review copies of such policies, procedures, and manuals from the MA plan.

Other UR issues on which skilled nursing centers should focus include:

- Emergency Services. Generally, emergency services are exempt from any prior authorization requirements. However, skilled nursing centers will want to pay close attention to how the contract defines “emergency services” and the timeframe for which they must notify the MA plan. Skilled nursing centers should also pay close attention to definitions of hospital and skilled nursing center readmissions within the contract, because readmission rates may partially drive reimbursement over time.
- Prior Authorization Carry-Over. To maintain continuity, prior authorizations for services, drugs, therapies, and equipment should carry over to new MA plans for certain periods of time upon patient enrollment.
- Identity of the Reviewer. The contract, or a policy or manual, should identify the party responsible for UR and payment decisions, which includes the right to deny payments for claims that are not medically necessary. While the MA plan may seek sole responsibility for this role, the MA plan occasionally may wish to delegate this function to an agent, such as a medical group or an IPA.² In either case, the skilled nursing center should ensure that qualified clinicians are part of the process.
- Standards for Review. Review how the contract defines “medical necessity” and the specific standards for it (*e.g.*, whether local or national standards apply, if the services must fall within a range of acceptable practice, and/or if the service must be the least invasive or costly). Additionally, ensure that the definition of “covered services” is the same in the UR program documents and in the patient materials.
- Sample Language Regarding Claim Denial for Failure to Comply with the UR Program:

Favorable Language: If the Provider fails to comply with the MA plan’s UR Program, the MA plan may deny payment for the services. If the MA plan’s decision to deny coverage for a claim is based solely on the Provider’s failure to identify a patient as a Member, to obtain prior authorization, to request a continued stay, or to provide medical records or other requested information (collectively, “Provider Noncompliance”), then the Provider shall be entitled to appeal the denial and submit the claim for review of medical necessity. Upon review, if the services for which the claim was submitted are found to be Medically Necessary and appropriate, determined in accordance with the MA plan’s standard clinical criteria without taking into consideration the Provider Noncompliance, the MA plan shall reverse the denial and pay the claim. Neither

² See Module I for a discussion of MA plan structures that include integration with a medical group or an IPA.

the MA plan nor the Member shall be responsible for payment for services correctly determined to be not Medically Necessary.

Unfavorable Language: If the Provider fails to comply with the MA plan's UR Program, the MA plan may deny payment for the services.

- Appeals of UR Decisions. Review the appeal rights for the skilled nursing center, whether in its own capacity or as an authorized representative of the patient. When the skilled nursing center appeals directly, the appeal rights and process will probably be set out in the contract, or a policy or manual incorporated by reference. However, these skilled nursing center appeal rights and processes may substantially differ from those afforded to the skilled nursing center when acting on behalf of the patient. Because skilled nursing center patients often lack the cognitive capacity needed to make legally binding decisions, and sometimes suffer from lack of engagement by legal decision makers such as family who live out-of-state, skilled nursing centers should have the ability to file appeals on behalf of their patients.

Sample Language Regarding UR Appeals:

Favorable Language: The Provider may appeal a UR decision by requesting reconsideration by the UR Committee within 30 days from the date of notification of the UR decision. The UR Committee shall consist of three individuals. The MA plan and the Provider shall each designate a skilled nursing center, and those two skilled nursing centers shall designate a third. Notwithstanding the foregoing sentence, no skilled nursing center of the UR Committee shall have been involved in making the initial determination or shall report to an individual involved in making the initial coverage determination. In making its request, the Provider may submit additional information for review in the reconsideration process regarding the services provided. The UR Committee will attempt to resolve the dispute. In attempting to resolve the dispute, the UR committee shall consult with at least one physician who is board-certified in the area of the services requested / provided. If the dispute cannot be resolved, the UR Committee shall issue a final decision. If either party is dissatisfied with this decision, it may request arbitration, as provided herein, by making the written demand for arbitration within 10 days from receipt of the UR Committee's final decision. The MA plan agrees that, when the Provider is authorized to act as the Member's authorized beneficiary in accordance with state law, the Provider may exercise any of the Member's rights.

Unfavorable Language: The Provider may appeal a UR decision by requesting reconsideration by MA plan's UR Committee within 30 days from the Provider's receipt of notification of the decision. The Provider may submit additional information for consideration in the review process with the request for reconsideration. If requested, the Provider shall serve on the MA plan's UR Committee without compensation and in accordance with procedures established by the MA plan. The UR Committee, following procedures set forth in the MA plan's Provider Manual, will attempt to resolve the dispute. In attempting to resolve the dispute, the UR Committee shall consult with at least one clinician

with training or experience in the area of the services provided. If the dispute cannot be resolved, the UR Committee shall issue a final decision.

Quality Assurance

Quality Assurance (“QA”) generally refers to procedures designed to promote the quality of healthcare services received by the skilled nursing centers. It may include elements of peer review and audits of care, medical protocols, credentialing, and patient satisfaction assessments. Thus, although UR and QA programs frequently work hand-in-hand, they often differ.

Sample Language Regarding QA Measures:

Favorable Language: As part of the Provider’s cooperation with the MA plan’s QA program, the Provider shall participate in the MA plan’s quality measurement program. The MA plan agrees that its quality measurement program shall use the quality measures chosen by the [*industry-standard quality measurement organization*] from time to time, including all definitions, standards, and protocols. If the MA plan amends its quality measurement program so that it is no longer consistent with the [*industry-standard quality measurement organization*], the Provider shall be entitled, upon 15 days’ written notice to the MA plan, to discontinue participating in the MA plan’s quality measurement program. If, for any period after the Provider discontinues participation in the MA plan’s quality-measuring program, any portion of the Provider’s payment, including any bonus or incentive, is based on the Provider’s participation in and satisfactory performance of the performance measures, the MA plan shall adjust the Provider’s compensation so that the MA plan is not penalized for discontinuing participation in the MA plan’s quality-measuring program.

Additional Favorable Language: The Provider shall cooperate with the MA plan in the operation of the MA plan’s QA program to review the medical appropriateness and quality of healthcare services furnished by the Provider to skilled nursing centers on an inpatient and outpatient basis. Such QA program will be established by the MA plan consistent with industry standard practices, including accepted industry measures and standards for measuring quality. When establishing clinical quality improvement goals for any period, the MA plan shall use reasonable efforts to coordinate with other government programs and private health insurance plans. This program shall include all elements covered in the MA plan’s QA Program Manual, which may be amended from time to time by the MA plan at its discretion and upon notice to the Provider. The Provider shall comply with and, subject to the Provider’s rights of appeal as provided for in the QA Program Manual, be bound by the MA plan’s QA Program. All documents and information received or obtained by either party during its activities pursuant to this section shall be held confidential by that party during and after the term of this Agreement and shall not be disclosed to any person without the prior written consent of the other party.

Unfavorable Language: The Provider shall cooperate with the MA plan in the operation of the MA plan’s QA program to review the medical appropriateness

and quality of healthcare services furnished by the Provider to skilled nursing centers on an inpatient and outpatient basis. Such QA program will be established by the MA plan in its sole and absolute discretion. This program shall include all elements covered in the MA plan's QA Program Manual, which may be amended from time to time by the MA plan at its discretion and upon notice to the Provider. The Provider shall comply with, and be bound by, the MA plan's QA program. All documents and information received or obtained by either party during its activities pursuant to this section shall be held confidential by that party during and after the term of this Agreement and shall not be disclosed to any person without the prior written consent of the other party.

When assessing the quality of healthcare delivered, it is important to select the correct quality metrics for a particular type of provider. Recently, Medicare Pioneer Accountable Care Organizations ("ACOs") in the Commonwealth of Massachusetts proposed the following quality measures for skilled nursing centers desiring to contract with their ACOs:³

- Staffing Standard. Skilled nursing centers should have strategies to address clinical staffing standards, such as low staff turnover, reliance on pool nurse's aides, and access to adequate interpreter services.
- Quality Improvement Efforts Standard. Skilled nursing centers should have strategies such as participating in collaborative quality improvement ("QI") work with the MA plan.
- Screening / Admission Standard. Skilled nursing centers should have strategies such as screening patients and determining whether to offer a bed within two hours of referral; and accepting direct admits for qualified patients from home, emergency rooms, and a clinician's office.
- Facility Environment Standard. Strategies for the skilled nursing center environment standard include an environment that: (a) meets the patient's expectations (food, cleanliness, noise, comfort); (b) ensures critical medications are available upon the patient's arrival; (c) necessary durable medical equipment in the patient's room; and (d) wireless internet availability.
- Care Systems Standard. Strategies for a care systems standard include: (a) training staff and implementing the INTERACT program (or its alternative) to reduce avoidable readmissions; (b) STAT radiology and laboratory services, including the availability of results within 4 hours after ordering; (c) STAT prescriptions delivered within 6 hours; and (d) ensuring that PT / OT is provided as ordered.
- Care Planning / Coordination Standard. These strategies include holding care planning meetings within three days of admission and notifying patient, his or her legal representative (if any), and primary care physician at least 48 hours prior to

³ We do not necessarily endorse these quality measures. There is, however, no nationally agreed upon quality measures for skilled nursing centers. Accordingly, we set forth this list of quality measures for discussion purposes only.

the meeting. Establishing and documenting a functional goal requirement for the patient to be transferred home is paramount. Care planning also includes an estimated discharge date (which may be mutually amended from time to time), weekly meetings of the interdisciplinary team, and appointment of a point person responsible for rehabilitation and clinical updates.

- Use of Standard Discharge Planning Checklist. These strategies include: (a) providing a typed list of medications to the patient and explaining any changes to that list; (b) identifying family / caregiver availability; and (c) explaining discharge instructions using the “teach-back” method.

Although these quality metrics were proposed by ACOs rather than MA plans, it would not be surprising to see MA plans embrace these or similar quality metrics given the lack of national quality measures for skilled nursing centers.

Claims and Payment

Generally, billing and payment provisions should be detailed and specific, and involve the following two time limits: (1) the time period from the date of service within which the skilled nursing center must submit a claim to the MA plan to be paid; and (2) the time period from the date the MA plan receives the claim and must pay the skilled nursing center. Important issues include:

- Utilization of Clearing Houses and Third Party Billing Companies. Because claims payment processing is more complicated for MA than “original” fee-for-service Medicare, if a skilled nursing center utilizes a claims clearing house or a third party billing company, the need to select such an agent who understands MA plan billing systems is absolutely crucial.
- Claims Submission (Timely Filing of Claims). An MA plan will generally require a skilled nursing center to submit a claim for payment within a time limit from the date of service. If the time limit is relatively short, however, such as 30 days, a skilled nursing center may want to negotiate for a longer time limit or, failing that, should negotiate for a clause that addresses special circumstances such as loss of key staff or significant hardware or software failure.

Sample Language for Claims Submission:

Favorable Language: The Provider shall submit to the MA plan all claims for reimbursement no later than ___ calendar days from the date Covered Services are provided or, in the case of a Third Party Claim or Coordination of Benefits Claim, upon receipt of notice of denial from a Primary Payor. The Provider acknowledges and agrees to a reduction in amounts due to the Provider under the contract if the Provider submits claims for which the MA plan is primary more than ___ but no later than ___ calendar days from the date Covered Services are provided. Specifically, the Provider shall receive only ___% of the amounts payable under the contract for claims received between ___ and ___ calendar days from the date of service. The Provider also acknowledges and agrees that, if the

Provider fails to submit claims for which the MA plan is primary within ___ calendar days from the date Covered Services are provided, the MA plan reserves the right to deny payment for such claims unless the Provider demonstrates just cause for the delay. The foregoing notwithstanding, no claim or payment shall be denied or reduced based upon a failure to submit a claim within a designated period if the delay in submission was: (i) due to an act or omission of the MA plan or of any third party involved in the Member's care and beyond the Provider's control, or (ii) resulted from the inability to properly identify the patient as a Member through no fault on the part of the Provider.

Neutral Language: The Provider shall submit claims for billable Covered Services within one year from the date of service, or, in those instances in which the MA plan is the secondary Payor, one year from the date of service or ___ days from the date that Provider receives notice of payment decision from the primary Payor, whichever is later. The Provider shall submit claims for encounter information for Capitated Services within ___ calendar days from the date of service or, in those instances in which the MA plan is the secondary Payor, ___ calendar days from the date that the Provider receives a notice of payment decision from the primary Payor. The MA plan may deny any claims submitted (i) after one year from the date of service; or (ii) in those instances in which the MA plan is the secondary Payor, one year from the date of service or ___ calendar days from the date upon which the Provider received notice of payment decision from the primary Payor, whichever is later; or (iii) greater than ___ calendar days after the MA plan has requested additional claim information from Provider.

- Clean Claims. An MA plan's obligation to pay claims is triggered when it receives a "clean claim," which is a claim that is complete with the necessary documentation so that the MA plan can determine whether the services are covered under the terms of its agreement with Enrollees. Accordingly, a skilled nursing center should review how the contract defines a clean claim to not only avoid payment disputes, but to also speed up the process of prompt payment.

Sample Language for Clean Claims:

Favorable Language: For purposes of this Agreement, a Clean Claim means a claim which contains all of the [UB-92] or [HCFA 1500] (or successor standard) data elements, and is submitted within the timeframes set forth herein.

Unfavorable Language: For purposes hereof, a Clean Claim shall mean, unless otherwise required by law or regulation, a claim which: (a) is submitted within the timeframes set forth herein; (b) contains appropriate and sufficient medical and patient data to allow the MA plan to pay the claim; (c) does not involve a coordination of benefits issue or subrogation; (d) is submitted in accordance with the formatting and submission requirements which may be established by the MA plan from time to time; and (e) has no defect, error, or other impropriety or other circumstance that may otherwise prevent timely processing of the claim.

- Late or Incorrect Payments. While the contract will generally provide a time frame in which an MA plan must pay a clean claim, the skilled nursing center may want to establish penalties if the MA plan makes a late payment. Such

penalties usually take the form of interest at an agreed upon interest rate. For example, the contract could require the MA plan to pay interest at the rate of 10% per annum on clean claims paid after 45 days of receipt. It is also possible that state statutes mandate the payment of interest at a specified interest rate for claims paid untimely.

- Arbitrary Adjustment. Some contracts may allow the MA plan to arbitrarily adjust claims and pay them at a level lower than when submitted by down-coding the claim. Thus, a skilled nursing center may want to negotiate for language that protects it by stipulating that the MA plan must notify the skilled nursing center of, and explain any variances from, acceptable coding standards (*e.g.*, the federal Correct Coding Initiative, etc.). Additionally, a skilled nursing center may want to include a contract provision that allows it to appeal any payment that does not conform to the MA plan's published edits.
- Take-Backs and Set-Offs. A "take-back" provision allows the MA plan to recover alleged overpayments from the skilled nursing center. Such provisions become problematic when a contract allows the MA plan an unlimited time period for recovery. Given the increased use of retrospective payment reviews by MA plans, a skilled nursing center should negotiate the MA plan's take-back to as limited a time period as possible (*e.g.*, one year or less after the claim has been adjudicated by the MA plan). Additionally, some contracts may allow the MA plan to correct processing errors by setting-off payment against any future payment made to the skilled nursing center. In any case, the skilled nursing center should have the unfettered right to advanced written notice of a set-off and the right to appeal any take-back, recoupment, or set-off before it occurs.
- Recoupment. Prior to initiating any single recoupment from a skilled nursing center, the MA plan should be required to provide a detailed letter to the skilled nursing center describing the basis for the recoupment, the process to be utilized to recoup the funds, the total recoupment amount, total number of claims, range of dates for the claims being recouped, and describing the skilled nursing center's appeal rights. An electronic file that shows the patient ID, dates of service, original claim numbers, dates of payment, amounts paid, and amounts recouped should be generated and provided by the MA plan. Some state laws governing the licensing of MA plans prohibit recoupment if the skilled nursing center objects timely to the letter notifying the center of such recoupment.

Insurance and Indemnification

Virtually every contract with an MA plan will contain language requiring the skilled nursing center and the MA plan to carry liability insurance of various types and with various minimum policy limits. It may even seek to include more specific provisions associated with the limits and other terms of the insurance policies. In addition to provisions involving liability insurance, it is also very likely that the contract will include language indemnifying one or both parties for liability that results from the actions of the other. This type of provision would require the

culpable party to bear the costs of such liability even if it is not covered by the other party's liability insurance policies.

In light of the potential liabilities facing both parties, skilled nursing centers should review insurance and indemnification provisions keeping the following objectives in mind: (1) how each party identifies, quantifies, and manages their own risks; (2) how each party transfers these risks to the other party; and (3) how each party will avoid assuming the risks transferred from the other party.

Both the MA plan and the skilled nursing center should carry professional liability insurance, general liability insurance; and directors and officers ("D&O") insurance. The insurance provisions in the contract should specify the following:

- The type and dollar amount of the coverage, including any limits on deductibles or retained risk;
- The duration of the coverage, including whether "tail" coverage, if applicable, is required;
- Whether the other party must approve the choice of insurance carrier or whether the insurance carrier must meet certain insurance company rating standards;
- The individuals covered by the insurance policies (each party is required to maintain coverage for itself, its employees, and its agents for their own acts and omissions); additionally, each party is responsible for maintaining coverage for its employees for health and disability insurance, workers' compensation, and unemployment coverage; and
- Immediate notification to the other party for any changes in insurance coverage; the other party subsequently should have the unilateral right to terminate the contract if the required coverage is lost or substantially diminished.

Sample Language for Insurance:

Favorable Language: Throughout the term of this contract, each party shall maintain, at its sole cost and expense, general liability and professional liability insurance coverage through commercial insurance or a self-insurance program in the amount of \$_____ per claim and \$_____ in the annual aggregate, as may be necessary to protect the party and its respective employees, agents, or representatives in the discharge of its or their respective responsibilities and obligations under this contract.

Language Binding Solely the MA plan: The MA plan shall furnish the Provider with evidence of such insurance coverage prior to execution of this contract. The MA plan shall give to the Provider immediate notice of any changes in the policy or policies of insurance or self-insurance maintained by the MA plan, and the MA plan shall require any insurer to give the Provider at least 30 days' advance notice of any cancellation, lapse, termination, or amendment of any policy of insurance.

Language Binding Solely on the Provider: The Provider shall furnish the MA plan with evidence of such insurance coverage prior to execution of this contract.

The Provider shall give to the MA plan immediate notice of any changes in the policy of insurance or self-insurance maintained by the Provider, and the Provider shall require any insurer to give to the MA plan at least 30 days' advance notice of any cancellation, lapse, termination, or amendment of any policy of insurance. In the event that coverage is of a claims-made variety, the Provider shall continue to maintain policies of insurance in effect to cover losses which arise during the term of this contract but which are reported after the term of this contract for a period of _____ years beyond the term or any renewal term of this contract. Failure to maintain such coverage shall be grounds for termination of this contract for cause. The Provider shall indemnify the MA plan for any loss incurred as a result of the Provider's failure to maintain such coverage, which obligation to indemnify shall survive the termination of this contract.

Generally, the MA plan should indemnify and hold harmless the skilled nursing center for the MA plan's acts and omissions. Likewise, the skilled nursing center should indemnify and hold harmless the MA plan for the skilled nursing center's acts and omissions. Thus, skilled nursing centers should carefully evaluate their contractual responsibilities and how those responsibilities and risks are allocated. Specifically, the skilled nursing center should be responsible for the following:

- Providing medical care to the Member that is consistent with the prevailing or community standard of care;
- Exercising professional judgment when evaluating the MA plan coverage denials;
- Complying with MA plan timing and documentation requirements for prior authorization and utilization review;
- Participating in the Member grievance processes, including external appeal processes; and
- Making decisions within the context of financial incentive plans.

Similarly, the MA plan should be responsible for the following:

- Controlling access to care through authorization/pre-authorization and referral policies, procedures, and decisions, disease management, coverage decisions and denials of coverage;
- The accuracy of the beneficiary database information;
- Selecting and de-selecting providers;
- Utilization management and quality assurance;
- Designing financial incentives to control costs;
- Ensuring that benefit plans comply with state and federal laws;
- Maintaining an infrastructure necessary to administer its operations;
- Developing processes for handling beneficiary grievances, including external appeal processes;

- The accuracy of information supplied by the MA plan; and
- Other acts that are solely within the control of the MA plan.

Sample Language for Indemnification:

Unfavorable Language (One-Sided in Favor of MA plan): The Provider agrees to indemnify and hold the MA plan, its employees, agents, and contracting parties (the Indemnified Parties) harmless from and against any and all liability, loss, damage, claims, fines, or expenses, including costs and attorney fees (or upon the option of the Indemnified Party, the Provider shall provide a defense to the Indemnified Party) which result from the alleged or actual negligence, recklessness, or intentional acts of the Provider, its employees, and agents in performance of this agreement. Intentional acts shall include, without limitation, criminal conduct, fraud, defamation, and violation of any individual's right to privacy.

Favorable Language (Mutual Indemnification): Each party agrees to indemnify and hold harmless the other party and its officers, employees, and agents from and against all fines, claims, demands, suits, actions, or costs, including reasonable attorney fees, of any kind and nature to the extent they arise by reason of the indemnitor's negligent, reckless, or intentional acts or omissions. Each party agrees to notify the other party promptly of any lawsuits, claims, or notices of intent to file a lawsuit based in any manner upon services rendered pursuant to this agreement, or if such party has knowledge of facts or any reason to believe, based on facts, that a claim or lawsuit may be filed.

Term and Termination

The term of a contract refers to its duration.

- Initial Term. Generally, the longer the initial term, the more financial risk the skilled nursing center takes. Obviously, for risk-based payment models, a longer initial term means a longer period of risk-based payment. But even skilled nursing centers negotiating contracts that do not have risk-based payment concepts should be cautious of long initial terms. If the initial term is greater than one year, a skilled nursing center should consider asking for the inclusion of contract language that adjusts payment rates for inflation. The general "All Items" Consumer Price Index ("CPI") is often used, but it may be more appropriate to use an inflationary measure that is more specific to inflation for health care services and supplies, such as the Medical Care Commodities and Medical Care Services CPI measures, which track increases in the costs of health care provider services.
- Renewal Provisions. Renewal provisions generally take one of the two forms: (1) a provision that requires the parties to enter into good faith negotiations to renew the contract within a certain time period; or (2) an "evergreen" clause that automatically renews the contract, so that the contract continues unless one of the parties take action to terminate it. For either form of renewal provision, a contract

may require the parties to give substantial advance notice to avoid automatic renewal or to trigger renegotiations.

Generally, payment rates are a key issue with renewal provisions because, unless the contract otherwise provides, the payment rates established during the initial term will continue to be the rates from the prior term. As such, it does not factor in inflation or other factors. Thus, a skilled nursing center should negotiate for a contract provision that: (a) requires the parties to renegotiate payment rates before renewal; (b) provides a pre-established rate change; or (c) provides a rate change methodology. Rate change mechanisms may include benchmarks such as the healthcare inflation index, fixed annual percentage change, or a change in Medicare/Medicaid reimbursement rates.

Sample Language for Term Renewal:

Favorable Language: Upon expiration of each Term, this contract shall automatically renew for an additional one-year term, unless either party gives written notice to the other party at least 45 days before the end of the Term of its desire to terminate the contract; provided, however, that the MA plan shall submit a proposed payment rate schedule to the Provider at least 90 days prior to the end of the contract term.

Additional Favorable Language: The parties shall enter into good faith negotiations regarding the renewal of the Contract at least 60 days before the completion of the initial Term; provided, however, that if an agreement cannot be reached on the terms of renewal before the expiration of the initial Term, either party may terminate the Contract upon 30 days' notice to the other party.

Unfavorable Language: Upon expiration of each Term, this contract shall automatically renew for an additional one-year term, unless either party gives written notice to the other party at least 120 days before the end of the Term of its desire to terminate the contract.

Termination provisions are important because they can greatly influence the financial relationship that a provider has with a MA plan. Thus, skilled nursing centers should ensure that the contract has the following termination provisions:

- Termination without Cause. This is a particularly important provision for skilled nursing centers because it allows them to get out of a contract if they are dissatisfied with the contract for any reason such as claims payment, utilization review, or beneficiary grievances.
- Termination for Cause. Skilled nursing centers should have the right to terminate the contract for specific events or conditions that prevent them from meeting their obligations under the contract. As such, skilled nursing centers should ensure that the following terms are specifically provided for and defined:
 - Notice. Some contracts may require either party to give the other party immediate notice of any event that gives rise to cause for termination. In other words, a party would have to self-report the event.

- Cure Period. Depending on the nature of the dispute, it may be appropriate to include a time period in which the other party can cure the breach prior to the contract terminating. However, in some instances, a cure period may not be appropriate when the Member's health or safety is in danger.
- For Cause. Specific events or conditions should be defined as "for cause" under the Contract. Skilled nursing centers should consider incorporating the following events under "for cause:"
 - Either party commits material breach of its obligations or covenants (after notice and some reasonable time to cure);
 - Cancellation of either party's general liability, errors and omission, or professional liability insurance;
 - The MA plan routinely fails to make payments on time;
 - Either party has a change in control of its business due to a merger or acquisition; or
 - The MA plan becomes insolvent, is adjudged as bankrupt, has a receiver appointed, fails to post a bond as required by the State, or makes general assignment for the benefit of creditors.
- Right and Obligations after Termination. Under state and federal laws, certain rights and obligations, such as continuing to treat beneficiaries until another provider can render services, may continue beyond the Contract Termination date. A skilled nursing center may want to ensure that such provisions contain language requiring the MA plan to continue paying the skilled nursing center for serviced rendered after the termination date at contract rates if the course of treatment started on or before the termination date. Additionally, the contract should contain a requirement that the parties may reconcile payment and beneficiary information after the Contract terminates.

Sample Language for Termination:

Favorable Language (for Termination without Cause by Either Party): Either party shall have the right to terminate this contract without cause at any time upon 90 days advance written notice to the other party.

Favorable Language (for Termination with Cause by Provider): The Provider shall have the right to terminate this contract immediately upon written notice to the MA plan in the event the MA plan fails to obtain or maintain any licenses or certifications required by applicable law or regulation. In addition, the Provider shall have the right to terminate this contract in the event the MA plan commits a material breach of this contract that is not corrected within 30 days of the MA plan's receipt of the Provider's written notice of such breach.

Favorable Language (for Termination with Cause by the MA plan): The MA plan shall have the right to terminate this contract upon written notice to the Provider in the event Provider's license or licenses to provide services or ability to participate in Medicare, Medicaid, or TriCare programs is terminated, suspended, or restricted in any material way which would affect the ability of the Provider to

furnish Covered Services to skilled nursing centers. In addition, the MA plan shall have the right to terminate this contract in the event the Provider commits a material breach of this Contract which is not corrected within 30 days of the Provider's receipt of the MA plan's written notice of such breach; provided, however, that the MA plan shall not have the right to terminate this contract if the breach is not reasonably capable of being corrected within 30 days and the Provider commences to cure the breach before the end of the 30-day period.

Favorable Language (Continuing Obligations After Termination): In the event of termination of this contract at the end of the term or otherwise, the MA plan shall reimburse the Provider in accordance with the terms of this contract for all services rendered to skilled nursing centers who were under the care of the Provider as of the date of termination. The Provider shall continue to provide necessary services to such skilled nursing centers at the rates provided for herein during the remaining course of treatment until the earlier of: (a) the end of such course of treatment; (b) the discharge of the Member from the Provider's facility; or (c) the Member's decision to enroll in another health plan.

Dispute Resolution

MA plans and Providers should ensure that the dispute resolution terms cover all possible disputes, including those related to coverage, payment, renewal, and termination. Skilled nursing centers should consider whether to include a timeframe for disputes to be initiated to ensure that disputes are submitted to the dispute resolution process in a timely manner. The parties should consider whether the subject of the dispute (for example, an objectionable new claims payment rule or contract amendment) may take effect during the pendency of the dispute, as well as whether the dispute resolution terms should survive termination of the contract.

Often, private arbitration may be preferable over resorting to judicial litigation for a variety of reasons. Coverage and payment disputes can involve hundreds of claims, creating disputes that can be too complex and too time consuming for judges and/or juries who have little familiarity with such disputes. A private arbiter with a health care background can more easily navigate coverage and payment disputes, the resolution of which usually requires extensive expert testimony by clinicians. Further, private arbitration usually is more expedient than judicial litigation in most jurisdictions.

Sample Language for Dispute Resolution:

Favorable Language: The parties will use good faith effort to resolve any disputes that arise under this Agreement using the following process.

(i) Meet and Confer Process:

Initiation: If the parties are unable to resolve any dispute through applicable internal appeal processes, if any, the parties agree to meet and confer within 15 days of a written request by either party in a good faith effort to informally settle any dispute. The parties each agree and understand that the meet and confer requirements set forth herein may be satisfied only by meeting each of the following requirements: (a) an actual

meeting must occur between executive level employees of the parties who have authority to resolve the dispute and are each prepared to discuss in good faith the dispute and proposed resolution(s) to the dispute, and (b) such meeting may take place either in person or on the telephone at a mutually agreeable time, and (c) unless otherwise mutually agreed by the parties, neither party is allowed to have legal counsel present at the meeting or to substitute legal counsel for the executive level employee, and (d) such meeting and all related discussions between the parties shall be treated in the same manner as confidential protected settlement discussions under the State Rules of Civil Procedure.

(ii) Voluntary Mediation: If the parties are unable to resolve any dispute through the meet and confer process set forth above, and desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to the American Health Lawyers Association (“AHLA”) prior to submitting a dispute to arbitration, or the parties may initiate such other procedures as they may mutually agree upon.

(iii) Binding Arbitration: If the parties are unable to resolve a dispute through the dispute resolution process set forth above, the parties agree that such dispute shall be settled by final and binding arbitration, upon the motion of either party, under the appropriate rules of the AHLA, as agreed by the parties. Any arbitrator must be either a judge, or an attorney licensed to practice law in the state of the provider’s principle place of business, who is in good standing with the state bar association, and has at least 10 years of experience with health care matters and the arbitration of managed care disputes. The parties each understand and agree that the exhaustion of any internal appeals processes and the “Meet and Confer” Process set forth above in Subsection (i) are conditions precedent to binding arbitration under this Subsection (iii). The arbitration shall be conducted in the City of _____, State of _____. The written demand shall contain a detailed statement of the matter and facts and include copies of all material documents supporting the demand. Except as provided below, arbitration must be initiated within one year after the date the dispute arose by submitting a written notice to the other party. For the purposes of filing for arbitration regarding a dispute over the MA plan’s alleged nonpayment or underpayment of clean claims under this Agreement, the parties agree that arbitration shall be filed within one year after the date of the MA plan’s notice of its final determination on provider’s internal appeal, if any, on such clean claims. The parties expressly agree that the deadlines to file arbitration set forth above shall not be subject to waiver, tolling, alteration or modification of any kind or for any reason except for fraud. The failure to initiate arbitration before such deadlines shall mean the complaining party shall be barred forever from initiating such proceedings. All such arbitration proceedings shall be administered by the AHLA or as agreed by the parties; however, the arbitrator shall be bound by applicable state and federal law, and shall issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that the decision of the arbitrator shall be final and binding as to each of them. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The arbitrator shall have no authority to

make material errors of law or to award punitive damages, or to add to, modify, or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award, which could not have been made by a court of law. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within 30 days of the entry of judgment on the award. The parties waive their right to a jury or court trial. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

Unfavorable Language: Provider and Plan agree to seek resolution of any dispute only through arbitration of that dispute in accordance with the terms of this Section, and not litigate any dispute in court.

(i) Notice of Dispute: If Provider has a dispute with Plan or any of its affiliates, it must send written notice to Plan to give Plan the opportunity to resolve the dispute informally through negotiation. Provider agrees to negotiate resolution of the dispute in good faith for no less than 120 days after it provides notice of the dispute. If the parties do not resolve the dispute within 120 days from receipt of notice of the dispute, either party may pursue resolution of the dispute through binding arbitration as set forth in this Section.

(ii) Class Action Waiver: Any dispute resolution proceedings, whether in arbitration or in court, will be conducted only on an individual basis and not in a class or representative action or as a named or unnamed member in a class, consolidated, representative or private attorney general action, unless both Provider and the Plan specifically agree to do so in writing following initiation of the arbitration.

(iii) Initiation of Arbitration Proceeding / Selection of Arbitrator: If Provider or Plan elects to resolve the dispute through arbitration, the party initiating the arbitration proceeding may initiate it only with the arbitration service then approved by the Plan in its provider manual.

(iv) Arbitration Procedures: Because the agreement between Provider and Plan concerns interstate commerce, the Federal Arbitration Act (“FAA”) governs the arbitrability of all disputes. If the arbitrator finds that Provider is the prevailing party in the arbitration, Provider will be entitled to recover reasonable attorney fees and costs only if the principal amount in controversy exceeds \$50,000. The arbitrator will make any award in writing but need not provide a statement of reasons. Such award will be binding and final, except for any right of appeal provided by the FAA, and may be entered in any court having jurisdiction over the parties for purposes of enforcement. The arbitration may be initiated only in, and all proceedings shall occur only in, the county of the Plan’s principal place of business.

Miscellaneous Issues

- Attorney Fees and Costs. Ensure that the contract expressly states that, if either party resorts to arbitration or litigation to enforce the terms of the contract, the substantially prevailing party in such arbitration or litigation, as determined by the arbiter or judge, shall be entitled to recover its reasonably attorney fees and costs. Without such a clause, it becomes cost-prohibitive for a skilled nursing center to dispute coverage and claims denials, because the attorney fees and costs incurred by the skilled nursing center may exceed the amount of the denied claims.

Sample Language for Attorney Fees and Costs:

Favorable Language: In any [legal action, arbitration, or dispute] between the parties to enforce the terms of this Agreement, the substantially prevailing party in such [legal action, arbitration, or dispute] shall be entitled to an award of its reasonable attorney fees and reasonable costs, in addition to any other relief to which such party may be entitled.

- Identification of the Parties. Ensure that the contract identifies the parties precisely. If, for example, an MA plan is national and has local affiliates, the contract should specify the correct local affiliate as the party to the contract. Otherwise, a healthcare provider may be obligated to provide services to, or be considered part of the network of, the MA plan's affiliates. Likewise, ensure that the contract properly lists your skilled nursing center operating entity, including any trade names used by such entity, as the provider party.
- Unilateral Changes. It is common for an MA plan to give itself the authority to make unilateral changes in the middle of a contract term by giving the healthcare provider a short period of notice. This means that, within 30 days or whatever notice period is required, the MA plan may, at its discretion, change the contract at any time. Skilled nursing centers that are comfortable with this concept should still guard against significant unwanted changes to the contract by ensuring that the notice requirement is clearly described. For example, the MA plan's provision of a "written or electronic" notice may appear to be sufficient, but this can be construed to allow the MA plan to provide such notice by posting a general update on its website. Thus, at the very least, the contract should say that notices of any material unilateral changes by the MA plan must be mailed to the Administrator of the skilled nursing center or another designated person. Skilled nursing centers that are not comfortable with the MA plan's ability to unilaterally change the contract should request deletion of this type of clause or ensure that they may terminate the contract without penalty if they do not agree to continue with the contract after the MA plan's unilateral change.
- Vague Language. If there is any vague language in the contract, a skilled nursing center should also ask the MA plan to replace such vague language with clear and unambiguous language. If a skilled nursing center signs the contract, by law it will be deemed to have understood any language in the contract. Vague contract language also may be a more subtle form of the MA plan making unilateral

changes mid-term. For example, phrases such as “as may be deemed necessary,” “from time to time,” or “modified or added at the discretion of the MA plan” may all grant the MA plan the sole discretion to make unilateral changes. Thus, the skilled nursing center should carefully review provisions involving such language.

- Entire Contract. While the Contract defines the rights and obligations of the relationship between the skilled nursing center and MA plan, the details of those rights and obligations are often found in the MA plan’s policies, procedures, and manuals that are incorporated by reference into the Contract. Because the Contract will likely require that a skilled nursing center comply with these referenced documents, it would be wise for the skilled nursing center to obtain written copies of all these documents.
- Nonexclusivity. Noncompete provisions in managed care contracts generally serve to prevent skilled nursing centers from contracting with other managed care plans. However, if a managed care contract is terminated for any reason, the beneficiary will typically change from one MA plan to another in order to stay within the same skilled nursing center. MA plan differences can be minimal from a patient perspective, and patients will normally prefer to stay in their current facility. The non-existence of noncompete clauses, therefore, is a key to preserving the skilled nursing center’s leverage in contract negotiation or re-negotiation periods. If an MA plan knows that it will lose beneficiaries to another MA plan, there is a greater likelihood that the MA plan will be reasonable during contract disputes (*e.g.*, prompt payment disputes) or contract rate negotiations. Skilled nursing centers should individually determine whether to accept such clauses in proposed contracts. In other states, we have seen providers reject such clauses on a unilateral basis and not part of any concerted action by them.