Best Practices Toolkit: Negotiating and Entering into Medicaid Managed Care Contracts

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I. Introduction

This Toolkit is designed to assist the Association’s members with evaluating the key terms of Medicaid managed care plan contracts with Medicaid Managed Care Organizations (“MCOs”). It identifies and describes the key contract clauses, in many instances providing examples of language that is favorable for nursing centers (“NFs”) and/or assisted living facilities (“ALFs”) (when applicable). Accordingly, this Toolkit 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 Medicaid managed care plan.

Although 39 states have contracted with MCOs for Medicaid services, the vast majority of beneficiaries enrolled in these programs are children and non-disabled adults. Increasingly, states are enrolling seniors and non-elderly adults with physical disabilities into capitated Medicaid MLTSS programs. As of the date of this Toolkit, 19 states have received waivers from the Centers for Medicare and Medicaid Services (“CMS”) for capitated Medicaid MLTSS programs, all of which include seniors and non-elderly adults with physical disabilities. Most of such waivers (14 of 19) cover or will soon cover a comprehensive set of benefits, including NF/ALF services, home and community-based services, acute and primary care, and behavioral health. We expect a rapid increase in the adoption of capitated Medicaid MLTSS programs for the remaining 31 states.

With the implementation of Medicaid MLTSS, the State’s provision of long-term care services will shift from a fee-for-service model to a capitated, managed care model. As a result, the Association’s NF/ALF members will have to negotiate contracts with one or more MCOs selected by the State. Although the managed care contracting process for the Medicaid MLTSS will have some similarities to other managed care programs (e.g., Medicare Advantage), this Best Practices Guidance should be helpful to the Association’s members as they negotiate and enter into Medicaid managed care contracts with MCOs. This guide includes examples of sample managed care contract language on specific issues.

Managed care contracts define several relationships: the NF’s/ALF’s relationship with the MCO, the MCO’s relationship with the State, and the State’s relationship with the federal government. Under most Medicaid MLTSS programs, the State Medicaid agency contracts with private entity MCOs and pays them a fixed (also known as “capitated”), monthly fee per beneficiary for assuming some or all of the financial risk for the delivery of long term care services. The MCOs, in turn, attempt to pass some of this financial risk to the NFs/ALFs.

II. Best Practices Before Negotiations

A. Research the MCO

Prior to negotiating a contract with an MCO, a NF/ALF should obtain as much knowledge as it can about the MCO, its parent organization (if applicable), and any subsidiaries (if applicable). A NF/ALF should gather the following information about the MCO:
• **Business Strategies.** Knowledge of the MCO’s strategies, such as whether the MCO is new to the geographic region, whether the MCO has already entered into managed care contracts (commercial, Medicare, or Medicaid) in the relevant market, and other pertinent information can create additional leverage for the NF/ALF when negotiating the terms of the managed care contract.

• **Financial Strength.** An MCO’s financial strength is important because the NF/ALF will be dependent on the MCO for payments over the term of the contract. As a result, the NF/ALF should review the MCO’s statistical and financial information gathered from state insurance departments or other agencies and any other information to evaluate the MCO’s financial solvency. It is also advisable to ask the MCO about its reinsurance policies (reinsurance is the process by which insurance companies themselves purchase insurance to guard against insolvency and spread the risk of unexpected excess claims) and any “stop-loss” provisions it has in place with the State (whereby the State agrees to put a ceiling on the potential losses of the MCO for a particular time period on a per-calendar quarter or yearly basis). Additionally, the MCO may be required to post a performance bond with the State, which would also be available to pay NF/ALF claims in the event of the MCO’s insolvency. If this is the case, wise to request verification of the bond.

**Reputation.** A NF/ALF should learn about the MCO’s reputation in the community. If the MCO lists its contracted providers in its marketing materials, the NF/ALF may want to contact them directly to learn more about the MCO and its operations. However, due to antitrust compliance concerns, the NF/ALF should avoid discussion of contract rates or other price-related terms with the other providers. A NF/ALF should assess the MCO’s ability to efficiently process claims, make payments to providers within established time limits, and provide utilization information in a format and within a time frame that helps a NF/ALF effectively manage care. Additionally, a NF/ALF can compare the MCO’s administrative performance in key areas to benchmarks in the managed care industry (e.g., percentage of days a claim is denied, length of time between a clean claim and payment, timelines for approval of prior authorization requests, etc.).

**B. Determine Your Key Objectives**

After gathering background information about an MCO, and prior to negotiation, a NF/ALF should identify its key objectives and negotiating points in order of importance. Specifically, the NF/ALF should identify its position concerning core contract issues such as Covered Services, financial arrangements, the parties’ obligations under quality and utilization review plans, and termination rights.

An essential part of negotiating is developing and determining one’s “bottom line” to negotiations. In other words, at what point is the NF/ALF willing to walk away from the negotiations without any contract with an MCO?
C. Other Pre-Negotiation Considerations

- **Antitrust Considerations.** In general, the antitrust laws (the Sherman Act, the Clayton Act, and the Federal Trade Commission Act)\(^1\) prohibit conduct among competitors that restrains trade. The federal agencies that enforce the federal antitrust laws, the Department of Justice and the Federal Trade Commission (collectively, the “Agencies”), generally treat arrangements between competitors that fix prices or allocate markets as “per se” illegal. If arrangements do not fall within a “per se” illegal activity, then the Agencies analyze them under a “rule of reason” analysis, wherein they weigh the pro-competitive benefits of the arrangement against the anti-competitive effects.

Current health care reform initiatives include value-based initiatives – incentivizing the quality of health care while reducing costs. Thus, providers are sharing information regarding cost of care, health care performance measures, and development of standardized performance expectations. However, the Agencies have opined that provider group activities can still raise antitrust concerns if the sharing of such information is used by the providers to facilitate joint contracting or joint fee schedule negotiations with MCOs. In order to comply with antitrust laws, provider networks must generally show that the providers are significantly integrated through financial risk-sharing arrangements and/or clinical integration.

- **Provider Networks.** If the State does not require MCOs to contract with all existing Medicaid-certified NFs/ALFs to maintain network adequacy, then Association members should consider developing one or more provider networks that allow them, as a group, to jointly negotiate contract rates with MCOs. Without an antitrust-compliant network, there exists some risk that MCOs may pit NFs against each other when establishing contract rates. Similar risks may exist for ALFs. Note that, if Association members establish provider networks, they should do so cautiously to avoid noncompliance with antitrust laws. To avoid violating antitrust laws, a provider network must include carefully crafted features, such as substantial financial risk and/or substantial clinical integration, prior to jointly negotiating contract rates. Antitrust compliance for provider networks is beyond the scope of this Guide, but a NF/ALF interested in this concept should engage qualified antitrust compliance legal counsel to advice on specific antitrust issues.

- **Understanding Your Current Rates and Costs.** It is unknown at this time whether the State will require MCOs to initially reimburse NFs/ALFs at financially equivalent rates during the initial operation of the Medicaid MLTSS program. NFs/ALFs should determine their existing rates for current services and determine their costs for providing such services. Ideally, NFs/ALFs should develop reporting mechanisms that allow them to study their costs and profitability for specific types of patients (e.g., by age, diagnosis, etc.) or episodes of care (e.g., stroke, congestive heart failure,

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\(^1\) 15 U.S.C. §§ 1, 12 & 45, respectively.
knee replacement, etc.). Even if these reporting mechanisms are not in place prior to contracting with the MCO, it is extremely important to develop these reporting mechanisms so that the NF/ALF can educate the MCO about costs of care and potentially deficient reimbursement rates during the term of the managed care contract or upon renewal.

III. Negotiating the Managed Care Contract: General Issues

- **Identification of the Parties.** Ensure that the contract identifies the parties precisely. If, for example, an MCO is national and has affiliates, the contract should specify the correct local affiliate operating within the State 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 MCO’s affiliates. Likewise, ensure that the contract properly lists your NF/ALF operating entity, including any trade names used by such entity, as the provider party.

- **Unilateral Changes.** It is common for an MCO to give itself the authority to make unilateral changes in the middle of a contract term on the condition that the MCO gives the healthcare provider 30 days’ notice. This means that, the MCO may, at its discretion, make changes to contract terms at any time, and only needs to provide 30 days’ notice to the provider of these changes. NFs/ALFs 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 MCO’s provision of a “written or electronic” notice to the NF/ALF may appear to be sufficient, but this can be construed to allow the MCO 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 MCO must be mailed to the Administrator of the NF/ALF or another designated person. NFs/ALFs that are not comfortable with the MCO’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 MCO’s unilateral change.

- **Vague Language.** If there is any vague language (i.e., language that is not exact or precise, and can be subject to interpretation) in the contract, a NF/ALF should also ask the MCO to replace such vague language with clear and unambiguous language. If a NF/ALF 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 MCO 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 MCO” may all grant the MCO the sole discretion to make unilateral changes. Thus, the NF/ALF should carefully review provisions involving such language.
- **Entire Contract.** While the Contract defines the rights and obligations of the NF/ALF and MCO, the details of those rights and obligations are often found in the MCO’s policies, procedures, and manuals that are incorporated by reference into the Contract. Because the Contract will likely require that a NF/ALF comply with these referenced documents, it would be wise for the NF/ALF to obtain written copies of all these documents, and review these documents thoroughly in advance of agreeing to any Contract terms.

- **Nonexclusivity.** Noncompete provisions in managed care contracts generally serve to prevent NFs/ALFs from contracting with other MCOs. However, if a provider’s contract with the MCO is terminated for any reason, the beneficiary may change from one MCO plan to another in order to stay within the same NF/ALF. MCO plan differences are minimal from a patient perspective, and patients will normally prefer to stay in their current facility. The non-existence of noncompete clauses, therefore, is key to preserving the NF’s/ALF’s leverage in contract negotiation or re-negotiation periods. If an MCO knows that it will lose beneficiaries to another MCO, there is a greater likelihood that the MCO will be reasonable during contract disputes (e.g., prompt payment disputes) or contract rate negotiations. NFs/ALFs 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.

- **Covered Services.** Members should carefully review how “Covered Services” are defined in the contract. Carefully review the contract to see if the MCO has “carved out” a subset of services from Covered Services. Carved-out services can be problematic for long term care providers, especially if the State or federal government mandates that NFs are responsible for providing such services. Similar mandates may exist for ALFs under state laws. NFs/ALFs must continue to meet state and federal laws regarding required services, so NFs/ALFs must ensure that all such services are Covered Services as defined in the managed care contract. If certain services are carved out, the NF/ALF will essentially lose the reimbursement associated with those services, which will have serious financial implications for the NF/ALF.

**Sample Language for Covered Services:**

**Favorable Definition:** Covered Services means those healthcare services, equipment, and supplies that are required by federal and state 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 MCO from time to time. Updates to Covered Services will be posted on our provider web portal.
IV. Negotiating the Managed Care Contract: Utilization Management and Quality Assurance Programs

A. Utilization Management

Utilization Management (“UM”) generally describes an MCO’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 MCO’s UM program is designed to evaluate healthcare on the basis of appropriateness, necessity, and quality. For example, an MCO 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. Thus, in reviewing an MCO’s UM program, the Association’s facility members should consider the following:

- **Review the UM Program.** In order to review an MCO’s UM program, NFs/ALFs will have to ensure that they receive the UM program information in its entirety. If a contract refers to the MCO’s UM program only by incorporating by reference the MCO’s policies, procedures, and manuals that address its UM program, the NF/ALF should request and review copies of such policies, procedures, and manuals from the MCO.

  **Sample Language Regarding the UM Program, in General:**

  **Favorable Language:** The Provider agrees to participate in and cooperate with the UM Program and QA Program (UM/QA Program) utilized by the MCO, 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 MCO’s UM/QA 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 UM Program and QA Program (UM/QA Program), as amended by the MCO from time to time in its sole discretion, utilized by the MCO to promote the efficient use of resources. The Provider shall comply with and, subject to the Provider’s right to appeal as provided in the UM/QA Program, shall be bound by such UM/QA Program.

- **Emergency Services.** Generally, emergency services are exempt from any prior authorization requirements. However, NFs/ALFs will want to pay close attention to how the contract defines “emergency services” and the timeframe for which they must notify the MCO. NFs/ALFs should also pay close attention to definitions of hospital and NF/ALF 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 MCOs for specified periods of time upon patient enrollment. NFs/ALFs should consider requesting a six-month period post-enrollment when the MCO agrees in the contract it will not terminate such pre-authorizations without advance notice and the opportunity for the patients/residents and / or NF/ALF to appeal substantial reductions in services. The intentions are to prevent the interruption of services while new assessments are occurring and keep patients informed about proposed changes. The failure to address this issue in the contract can lead to significant problems and disruptions to service delivery.

• **Identity of the Reviewer.** The contract, or a policy or manual, should identify the party responsible for UM and payment decisions, which includes the right to deny payments for claims that are not medically necessary. While the MCO may seek sole responsibility for this role, the MCO occasionally may wish to delegate the UM to an agent. In either case, the NF/ALF should ensure that qualified clinicians with relevant expertise 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 UM program documents and in the patient/resident materials.

**Sample Language Regarding Claim Denial for Failure to Comply with the UM Program:**

**Favorable Language:** If the Provider fails to comply with the MCO’s UM Program, the MCO may deny payment for the services. If the MCO’s decision to deny coverage for a claim is based solely on the Provider’s failure to identify a patient/resident 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 MCO’s standard clinical criteria without taking into consideration the Provider Noncompliance, the MCO shall reverse the denial and pay the claim. Neither the MCO 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 MCO’s UM Program, the MCO may deny payment for the services.
• **Appeals of UM Decisions.** Review the appeal rights for the NF/ALF, whether in its own capacity or as an authorized representative of the patient. When the NF/ALF 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 NF/ALF appeal rights and processes may substantially differ from those afforded to the NF/ALF when acting on behalf of the patient. Because NF/ALF patients often lack the mental capacity needed to make legally binding decisions, NFs/ALFs should have the ability to file appeals on behalf of their patients/residents.

**Sample Language Regarding UM Appeals:**

**Favorable Language:** The Provider may appeal a UM decision by requesting reconsideration by the UM Committee within 30 days from the date of notification of the UM decision. The UM Committee shall consist of three individuals. The MCO and the Provider shall each designate a member, and those two members shall designate a third. Notwithstanding the foregoing sentence, no member of the UM 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 UM Committee will attempt to resolve the dispute. In attempting to resolve the dispute, the UM 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 UM 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 UM Committee’s final decision. The MCO 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 UM decision by requesting reconsideration by MCO’s UM 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 MCO’s UM Committee without compensation and in accordance with procedures established by the MCO. The UM Committee, following procedures set forth in the MCO’s Provider Manual, will attempt to resolve the dispute. In attempting to resolve the dispute, the UM 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 UM Committee shall issue a final decision.
B. Quality Assurance

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

Sample Language Regarding QA Measures:

Favorable Language: As part of the Provider’s cooperation with the MCO’s QA program, the Provider shall participate in the MCO’s quality measurement program. The MCO 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 MCO 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 MCO, to discontinue participating in the MCO’s quality measurement program. If, for any period after the Provider discontinues participation in the MCO’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 MCO shall adjust the Provider’s compensation so that the MCO is not penalized for discontinuing participation in the MCO’s quality-measuring program.

Additional Favorable Language: The Provider shall cooperate with the MCO in the operation of the MCO’s QA program to review the medical appropriateness and quality of healthcare services furnished by the Provider to Members on an inpatient and outpatient basis. Such QA program will be established by the MCO consistent with industry standard practices, including accepted industry measures and standards for measuring quality. When establishing clinical quality improvement goals for any period, the MCO shall use reasonable efforts to coordinate with other government programs and private health insurance plans. This program shall include all elements covered in the MCO’s QA Program Manual, which may be amended from time to time by the MCO 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 MCO’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 MCO in the operation of the MCO’s QA program to review the medical appropriateness and quality of healthcare services furnished by the Provider to Members on an inpatient and outpatient basis. Such QA program will be established by the MCO in its sole and absolute discretion. This program shall include all elements covered in the MCO’s QA Program Manual, which may be amended from time to time by the MCO at its discretion and upon notice to the
Provider. The Provider shall comply with, and be bound by, the MCO’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 NFs/ALFs desiring to contract with their ACOs.2

- **Staffing Standard.** NFs/ALFs 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.** NFs/ALFs should have strategies such as participating in collaborative quality improvement (“QI”) work with the MCO.

- **Screening / Admission Standard.** NFs/ALFs 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 NF/ALF 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 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

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2 We do not necessarily endorse these quality measures. There is, however, no nationally agreed upon quality measures for NFs/ALFs. Accordingly, we set forth this list of quality measures for discussion purposes only.
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.

**V. Negotiating the Managed Care Contract: 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 NF/ALF must submit a claim to the MCO to be paid; and (2) the time period from the date the MCO receives the claim and must pay the NF/ALF.

**A. Claims**

- **Claims Submission (Timely Filing of Claims).** An MCO will generally require a NF/ALF 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 NF/ALF 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 MCO 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 MCO 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 MCO is primary within ___ calendar days from the date Covered Services are provided, the MCO 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 MCO 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 MCO 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 MCO is the secondary Payor, ___ calendar days from the date that the Provider receives a notice of payment decision from the primary Payor. The MCO may deny any claims submitted (i) after one year from the date of service; or (ii) in those instances in which the MCO 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 MCO has requested additional claim information from Provider.

- **Clean Claims.** An MCO’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 MCO can determine whether the services are covered under the terms of its agreement with Enrollees. Accordingly, a NF/ALF 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 MCO 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 MCO 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.
B. Payment

- **Late or Incorrect Payments.** While the contract will generally provide a timeframe in which an MCO must pay a clean claim, the NF/ALF may want to establish penalties if the MCO 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 MCO 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 MCO to arbitrarily adjust claims and pay them at a level lower than when submitted by down-coding the claim. Thus, a NF/ALF may want to negotiate for language that protects it by stipulating that the MCO must notify the NF/ALF of, and explain any variances from, acceptable coding standards (e.g., the federal Correct Coding Initiative, etc.). Additionally, a NF/ALF may want to include a contract provision that allows it to appeal any payment that does not conform to the MCO’s published edits.

- **Take-Backs and Set-Offs.** A “take-back” provision allows the MCO to recover overpayments from the NF/ALF. Such provisions become problematic when a contract allows the MCO an unlimited time period for recovery. Thus, a NF/ALF may want to negotiate the MCO’s take-back to a limited time period (e.g., one year after the claim has been adjudicated by the MCO). Additionally, some contracts may allow the MCO to correct processing errors by setting-off payment against any future payment made to the NF/ALF. In any case, the NF/ALF 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.

- **Risk-Based Payment Structures.** MCOs may compensate NFs/ALFs in a manner that requires the NFs/ALFs 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) capping total payments by paying per diem fees for specified maximum lengths of admission (also referred to as “length of stay” or “LOS” caps); (3) ascribing a certain amount of reimbursement to patient outcomes, quality indicators, patient satisfaction surveys, and/or similar value-based concepts; and (4) capitation models, where NFs/ALFs are paid a fixed fee per Member per month. If the contract calls for any risk-based payment method, the contract essentially shifts financial risk to the NF/ALF. If entering into a contract with risk-based payment structures, a NF/ALF 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 Member utilization rates, demographics, and acuity trends to determine whether the acceptance of financial risk could become too great over the contract term.
• **Recoupment.** Prior to initiating any single recoupment from a NF/ALF, the MCO should be required to provide a detailed letter to the NF/ALF 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 NF’s/ALF’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 MCO.

**VI. Negotiating the Managed Care Contract: Insurance and Indemnification**

In light of the potential liabilities facing both parties, NFs/ALFs 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.

**A. Insurance**

Both the MCO and the NF/ALF 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 MCO. The MCO shall furnish the Provider with evidence of such insurance coverage prior to execution of this contract. The MCO shall give to the Provider immediate notice of any changes in the policy or policies of insurance or self-insurance maintained by the MCO, and the MCO 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 the Provider. The Provider shall furnish the MCO with evidence of such insurance coverage prior to execution of this contract. The Provider shall give to the MCO 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 MCO 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 MCO 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.

B. Indemnification

Generally, the MCO should indemnify and hold harmless the NF/ALF for the MCO’s acts and omissions. Likewise, the NF/ALF should indemnify and hold harmless the MCO for the NF’s/ALF’s acts and omissions. Thus, NFs/ALFs should carefully evaluate their contractual responsibilities and how those responsibilities and risks are allocated. Specifically, the NF/ALF 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 MCO coverage denials;
• Complying with MCO 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 MCO 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 MCO; and

• Other acts that are solely within the control of the MCO.

Sample Language for Indemnification:

Unfavorable Language (One-Sided in Favor of MCO): The Provider agrees to indemnify and hold the MCO, 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 indemnitee’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.

VII. Negotiating the Managed Care Contract: Term and Termination

A. Term

The term of a contract refers to its duration.

- **Initial Term.** Generally, the longer the initial term, the more financial risk the NF/ALF takes. Obviously, for risk-based payment models, a longer initial term means a longer period of risk-based payment. But even NFs/ALFs 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 NF/ALF 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 NF/ALF 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 MCO 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.

B. Termination

Termination provisions are important because they can greatly influence the financial relationship that a provider has with a MCO. Thus, NFs/ALFs should ensure that the contract has the following termination provisions:

- **Termination without Cause.** This is a particularly important provision for NFs/ALFs 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.** NFs/ALFs 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, members 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. NFs/ALFs should consider incorporating the following events under “for cause:”
  
  - Either party commits material breach of its obligations or covenants (after some reasonable time to cure);
  - Cancellation of either party’s general liability, errors and omission, or professional liability insurance;
  - The MCO 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 MCO 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 NF/ALF may want to ensure that such provisions contain language requiring the MCO to continue paying the NF/ALF for services 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 MCO in the event the MCO 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 MCO commits a material breach of this contract that is not corrected within 30 days of the MCO’s receipt of the Provider’s written notice of such breach.
Favorable Language (for Termination with Cause by the MCO): The MCO 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 Members. In addition, the MCO 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 MCO’s written notice of such breach; provided, however, that the MCO 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 MCO shall reimburse the Provider in accordance with the terms of this contract for all services rendered to Members who were under the care of the Provider as of the date of termination. The Provider shall continue to provide necessary services to such Members 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.

VIII. Negotiating the Managed Care Contract: Dispute Resolution

MCOs and Providers should ensure that the dispute resolution terms cover all possible disputes, including those related to coverage, payment, renewal, and termination. NFs/ALFs 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.

Sample Language for Termination:

Favorable Language: The parties will use good faith effort to resolve any disputes that arise under this Agreement. However, if any dispute does not arise between the parties that relates to or arises from this Agreement and the parties have not been able to resolve the dispute through an informal means within 15 days, either party may elect to have the dispute arbitrated in accordance with the terms set forth herein made a part hereof.