The Future is Now –Preparing for the New World of Medicaid Managed Care, Contracting with Private Health Plans and Development of Community Care Networks

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Overview & Outline

- Topical Introduction and Current Operational Framework
- Dual Demonstrations, Dual Eligible Health Plans, Medicaid Managed Care, and Community Care and Long-Term Services and Supports (LTSS)
- Preparing for Medicaid Managed Care and Contracting with Health Plans
- Strategies for Contracting with Health Plans (Appendix A)
- Potential for Establishment of Networks of Community Care Providers, Including Overview of Antitrust Risks, Risk Bearing Model, Clinical Integration Model, and Super Messenger Model (See also Appendix B)
- Case Study of Hypothetical Community Care Network Super Messenger Model
- Other Legal and Business Issues Associated with Community Care Networks

Duals Demonstration Update

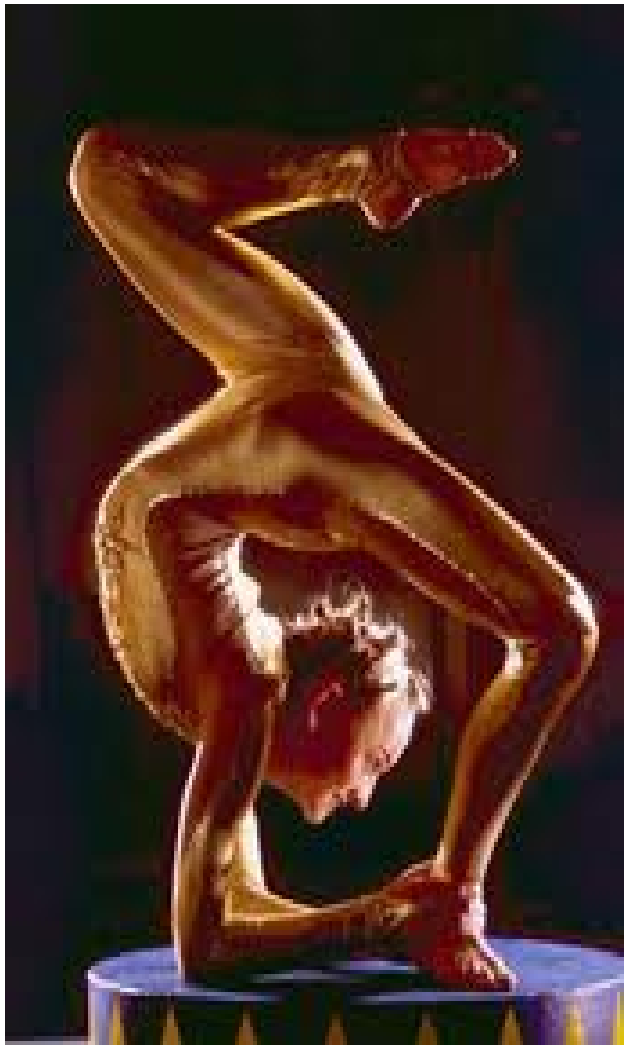
- Variety of Issues re Structures/Populations of "dual eligibles"
- Rates – Medicare & Medicaid "rate floors"
- Any Willing Provider, Credentialing & Network Adequacy
- Enrollment
- Rights to "Opt Out" of Medicare Portion

Movement to Managed Care

- Transfer of Responsibility and Risk
- Cost Certainty and Cost Containment

Why Managed Care?

- Less Transparency
- Benefit Flexibility



Provider Credentials & Network Adequacy

- Any Willing Provider ("AWP")
- Requires Plan Acceptance
- Does Not Guarantee Referrals

Provider Credentials & Network Adequacy (1)

- If no AWP
  - Network Adequacy
- Medicare
  - 3-prong analysis:
    1) Minimum provider to enrollee ratio
    2) Max travel distance to providers
    3) Max travel time to providers
- Medicaid
  - State dependent

Provider Credentials & Network Adequacy (2)

- United Healthcare Example
  - Terminations of 2000 physicians in Connecticut
  - Complaint filed and TRO issued
  - CMS determines that Medicare network adequacy requirements met despite terminations
  - Case pending before 2nd Circuit Court of Appeal

What Can Network Accomplish?

- For the health of the communities served there are three key issues a network may address:
  1. Improving the patient experience of care (including quality and satisfaction);
  2. Improving the health of populations; and
  3. Reducing the per capita cost of health care.

Benefits of a Network Model (1)

- Single contracting entity - ease of administration to payers
- Integration - simpler to connect to one main entity rather than multiple
- Uniform policies and procedures
- Uniform reporting
- Ability to vertically integrate “best practice” models

Benefits of a Network Model (2)

- Efficiencies-what are the redundant administrative business functions the network office could perform?
  - Contracting
  - Billing
  - Credentialing
- Ability for participating agencies to focus on core business delivery

Considerations in Developing a Community Care Network

- Outline of Topics To Be Covered
  - Antitrust Law and Related Risks
  - Primary Provider Model
  - Financially Integrated Risk Bearing Model
  - Clinical Integration Model
  - Super Messenger Model
  - Other Legal Considerations

Applicable Antitrust Restrictions: Horizontal and Vertical Restraints

- **Horizontal Restraints**
  - Agreement between actual/potential competitors to restrain competition in some way
  - E.g., network providers agree to jointly negotiate with payers
- **Vertical Restraints**
  - Agreements between suppliers and customers that restrain competition in some way
  - E.g., Most-Favored Nation clauses in managed care agreements (network being required by Plan to give it better pricing than Plan's competitors)

Per Se Violations

- Types of activities that constitute per se violations:
  - **Price Fixing** (agreement among competitors that raises, lowers, or stabilizes prices or competitive terms)
  - **Market Allocations** (agreement among competitors to assign sales territories or customers)
  - **Certain Group Boycotts** (agreement among competitors not to do business with targeted individuals or businesses)
  - **Certain Tying Arrangements** (agreement to sell product on condition that the buyer also purchase a tied product)

Escaping the Per Se Rule: Integration

- **True JVs may avoid per se treatment**
- **Sham JVs are just cartels (per se rule applies)**
- **Rationale: Procompetitive ends may require the use of anticompetitive means**
  - A JV may produce significant efficiencies or a new/improved product (pro-competitive effects) through suspect conduct (e.g., price fixing)
  - Thus, restraints are subordinate and collateral to a separate, legitimate transaction (ancillary restraints)
- **Healthcare JVs: Look for substantial financial risk sharing (and/or, perhaps, clinical integration)**

Joint Ventures

- Cooperative or concerted action among two or more otherwise independent competitors.
- Key to a legitimate joint venture, as opposed to illegal agreement among competitors, is economic integration
- Integration can be in the form of capital contributions, shared risk of loss, or consolidating business functions.

Network Joint Ventures - 1

- Over the past 20 years, many physician organization joint ventures – such as IPAs and PPOs – have been challenged by antitrust authorities.
- Primary claim is generally that they are insufficiently integrated, so joint payer negotiations constitute price fixing and *per se* illegal.
- Not protected by negotiating through agent (i.e., improperly structured messenger model): seen as indirect price-fixing.

Network Joint Ventures - 2

- In statements of Antitrust Enforcement Policy in Healthcare, DOJ/FTC established a "safety zone" for certain physician network joint ventures.
- If requirements are met, joint price negotiations will not be challenged.
- One of the requirements is that physicians/providers "share substantial risk," as this demonstrates financial integration.
- Shared financial risk
  - Network accepts capitation.
  - Accept percentage of premium.
  - Withhold percentage owed to participants unless meet cost containment or other legitimate goals.
  - Agree to provide cluster of services (i.e., bone marrow transplant) for fixed all-inclusive case rate.

Network Joint Ventures - 3

- Statements of Enforcement Policy introduced concept of clinical integration.
- FTC since has issued opinions outside of safety zone. Finding clinical integration can be sufficient to permit joint activities among competitors.
- Features approved included shared access to electronic clinical information, enforced clinical practice protocols, quality goals and benchmarks together with sanctions for non-compliance.
- Statement of Enforcement Policy regarding ACOs presumes ACOs are clinically integrated if meet CMS requirements.

Continuum of Models

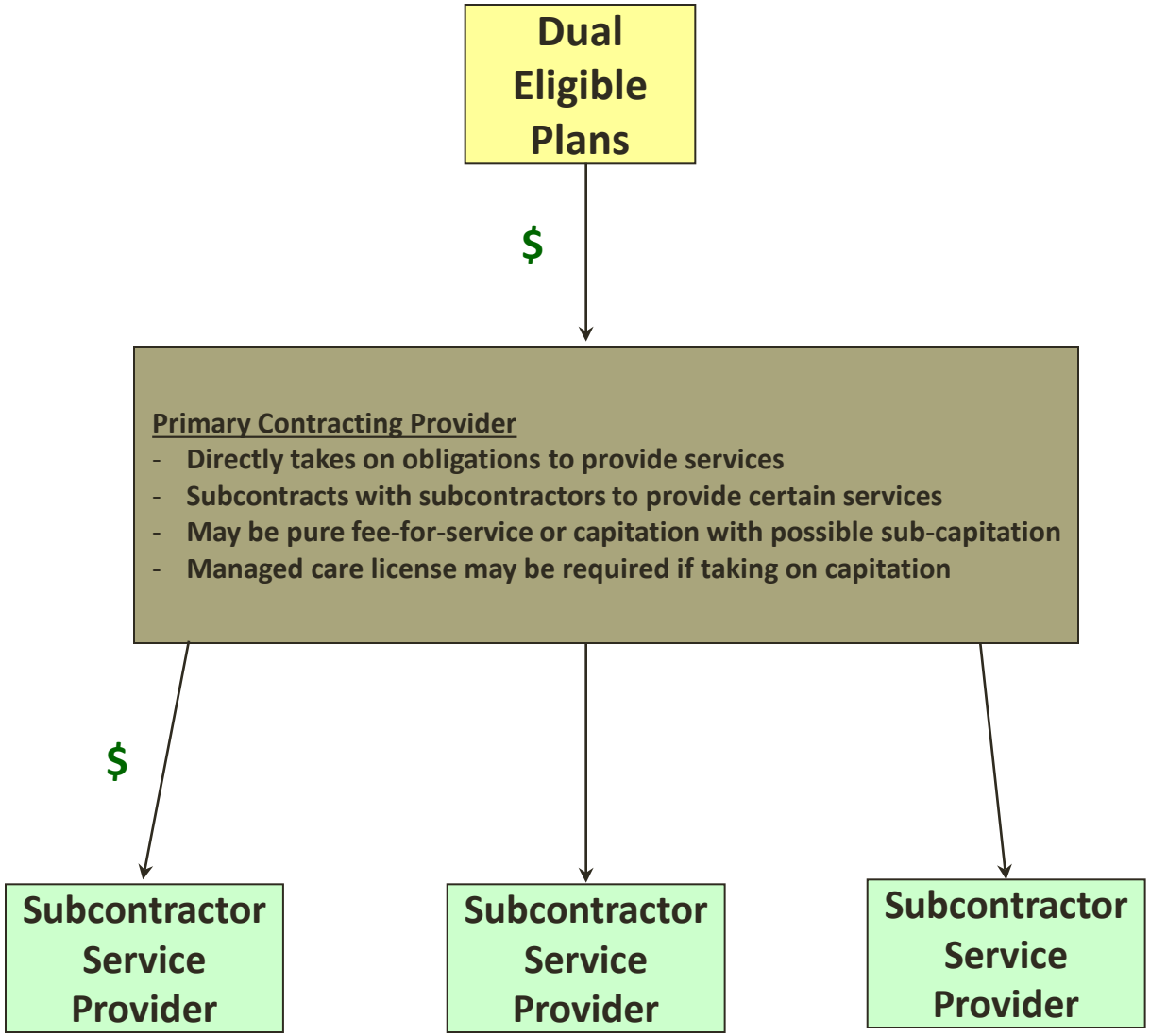
More Integrated

Less Integrated

Primary Provider Model

- Reduced antitrust risks
- Depending on structure, may require primary provider to obtain managed care license (in California limited Knox-Keene License possibly needed)
- Simplified option
- May be more appealing to plans
- Does not involve as much collaboration or coordination and opportunity for synergies between providers
- May be more difficult to obtain buy-in from subcontractors (Less independence and flexibility)
- Not really a network

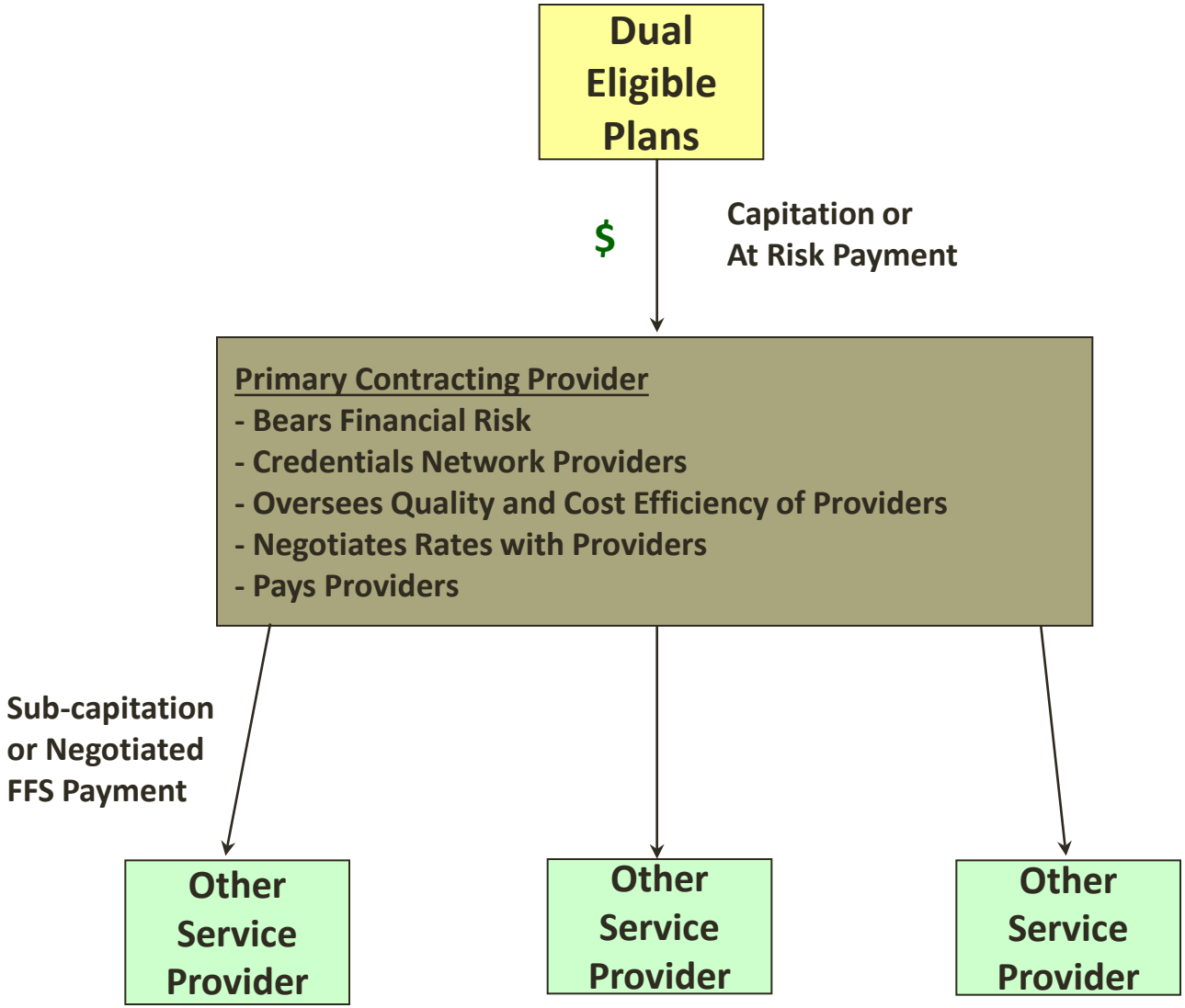
PRIMARY PROVIDER MODEL



Financially Integrated Networks (Risk Bearing Model)

- Typically established for sole purpose of contracting with Plans on a risk basis.
- Centralized billing/processing of capitation payments, quality assurance, utilization review and limited other administrative functions.
- If percentage thresholds in “safety zone” satisfied, federal agencies won’t challenge absent extraordinary circumstances.
- If not in “safety zone”, apply rule of reason analysis described in Policy Statements to assess antitrust compliance.

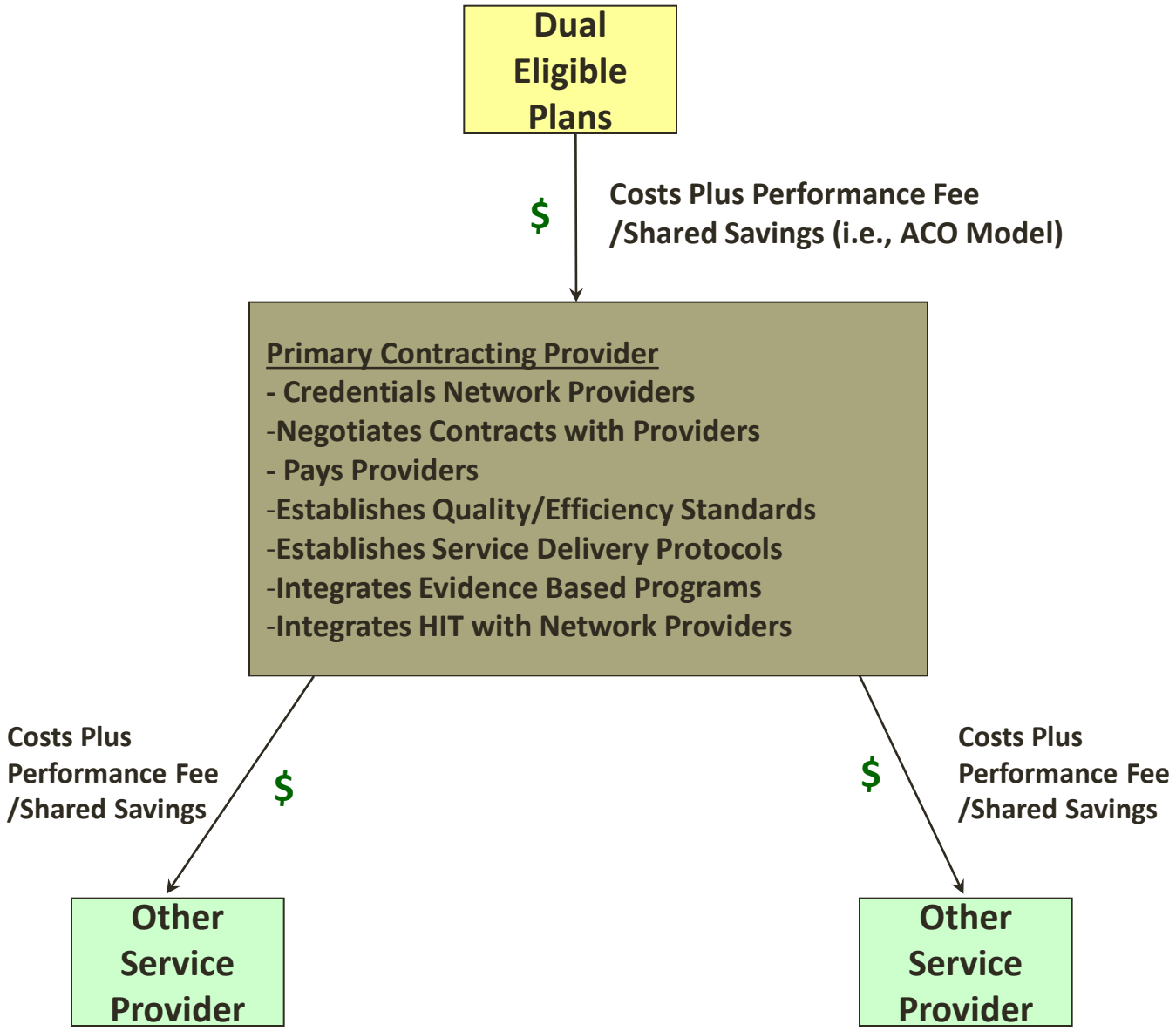
RISK BEARING MODEL



Clinically Integrated Networks

- Members typically would not share substantial financial risk.
- No safety zone, but rule of reason analysis if substantial clinical integration exists.
- Key: arrangement offers the potential for creating significant efficiencies, and the agreement on pricing is reasonably necessary to realize those efficiencies.

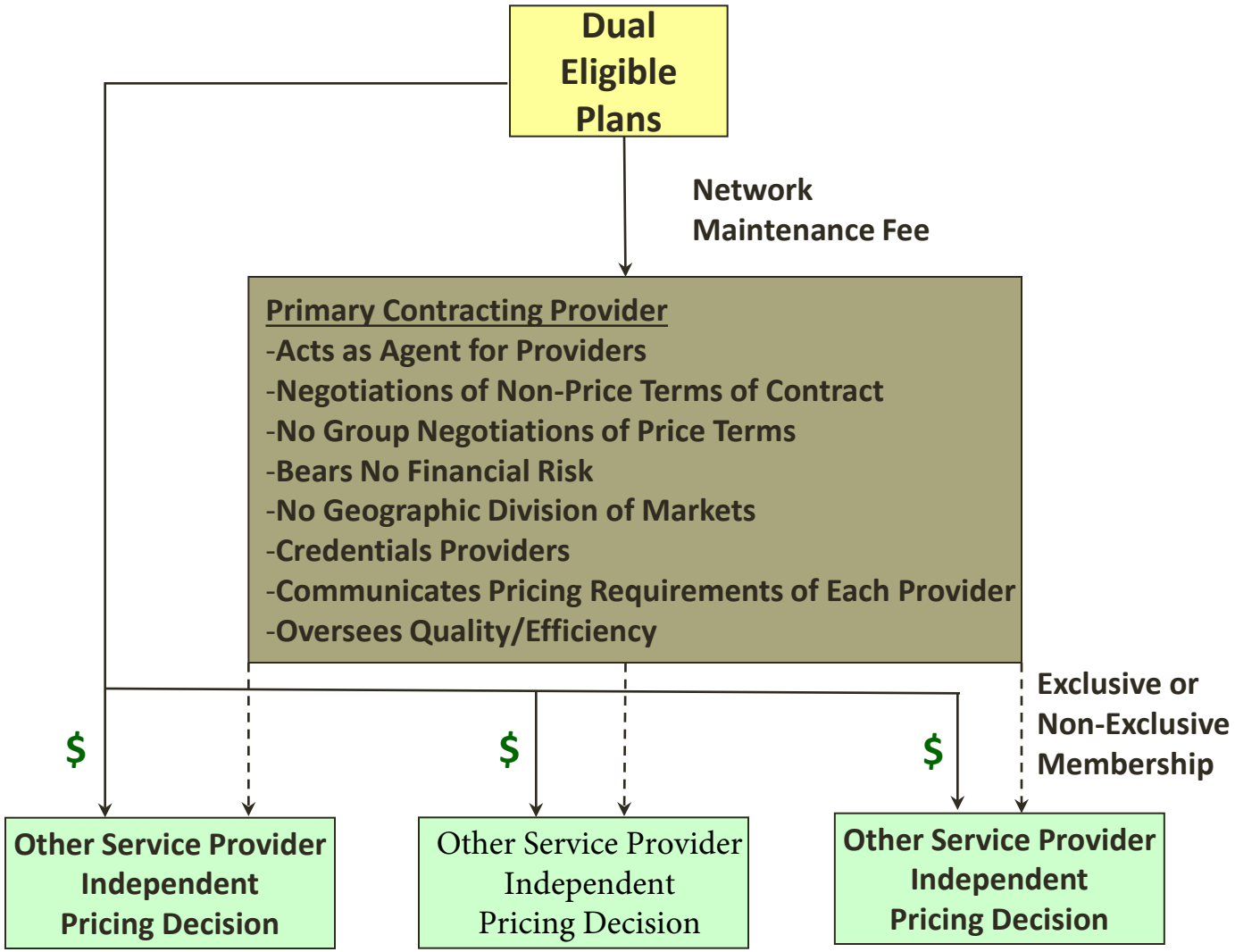
CLINICAL INTEGRATION MODEL



Super Messenger Model Overview

- The Network will act as agent for providers in negotiation of contracts with Plans, other than price and price terms. In the future, other types of providers may be added.
- Each provider would individually set the range of pricing and price terms (such as time for payment etc.) it is willing to accept from the Plans.
- The providers would not be permitted to share pricing information. The Network staff would be ethically walled off from Partners staff to ensure confidentiality of pricing information.
- Network would communicate price and price terms to plans, but would not negotiate prices collectively.
- If contracts meet the price and other terms acceptable to providers, the Network would execute a contract as agent for providers and notify provider.
- Plans would pay provider directly for services provided by such provider.

SUPER MESSENGER MODEL



Other Considerations: Super Messenger Model

- Coordinate care and best practices amongst participants
- No pricing or rate sharing to avoid legal risks
- No geographic division of markets (Community Providers should have ability to compete in markets)

Hypothetical Home & Community Services Network Plan (Super Messenger Model – A Prospective Case Study)

- **Home & Community Services Network**
  - **Collaboration:** A collaborative effort to bring efficiencies and value to participating network Community Care Providers (Community Providers) and the dual eligible health plans (Plans) that contract with the Community Providers
  - **Administration:** The Network will act as network administrator for participating Community Providers sites

Strategies for Funding the Cost of the Network Resources

- Capital contributions at founding
- Negotiation of network maintenance fees from Plans (particularly for delegated Plan administrative responsibility)
- Fees from members/contractors offset by administrative savings

Network Administrator Entity

- **Separate Entity:** The network administrator entity could be a separate entity (Newco) from the Community Providers' participants.
- **Type of Entity:** Newco could be a limited liability company (LLC), due to flexibility in management structure and reduced governance obligations.
- **Purpose:** Newco's purpose could be limited to acting as a network administrator for provider related activities and contracting for Community Providers' participants located in a certain region

Ownership

- Each participant could be a Member of Newco and could be provided with equal ownership (but typically tied to amount of capital contribution)
- Each participant could be expected to make an equal capital contribution to Newco to cover costs with establishing and staffing Newco

Governance

- Newco could be a manager managed LLC, but with membership participation in governance.
- Manager or managing board would be responsible for day-to-day management of Newco, with certain approval rights reserved to the Members.

Governance

- Approval rights of Members could include, among others, the following (with some requiring majority and some requiring super-majority approval):
  - Sale of substantially all the assets of or merger of Newco
  - Encumbering assets of Newco
  - Hiring or firing the CEO of Newco
  - Approving admission of new Members or to allow transfer of a Member's interests, other than transfers to affiliates
  - Requiring or permitting additional capital contributions
  - Amending organizational document
  - Annual budget

Meetings of Members

- Operating Agreement could provide for periodic and special Member meetings and provide for:
  - No sharing of pricing information in such meetings or otherwise
  - No division of markets
  - Coordination of care and best practices amongst participants
  - Consideration of Member suggestions regarding operational issues

Participating Provider or Membership Agreement

- Each participant could enter into a Participating Provider or Membership Agreement with Network/Newco.
- Agreement will address, among other things:
  - Term of Agreement and Termination Rights
  - Agreement to comply with Programs, Policies and Procedures of Network/Newco (including utilization review, quality management and reporting)
  - The Pricing requirement and terms for the specific contracting Community Provider (rates and terms that Community Provider is willing to accept)
  - Service obligations of Network/Newco
  - The scope of agency of the Network/Newco to act on behalf of Community Provider and enter into contracts
  - Insurance obligations of parties
  - Billing, reconciliation and audit rights of parties
  - Staffing and administrative services provided by Network/Newco

Other Business & Legal Issues Associated with Establishment of Community Care Networks

- Who can networks be marketed to other than plans?
  - Accountable Care Organizations (Commercial/Medicare)
  - Health Systems
  - Medical Homes
  - Large Employers

Other Business & Legal Issues Associated with Establishment of Community Care Networks

- Fraud and abuse risks
  - Federal and state anti-kickback statutes
  - State self-referral laws, and Federal Stark law issue possible if there is physician involvement
- Gainsharing opportunities with plans and other providers
  - Federal civil monetary penalty statute

Wrap-Up & Questions?

APPENDIX A

Contracting Issues

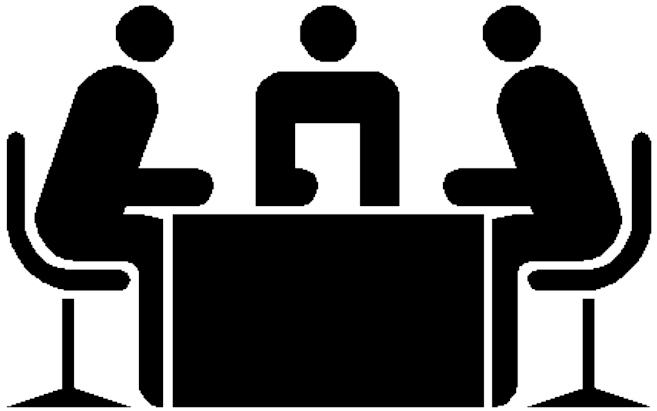
Plan Set Up – Global Issues

- These issues may be considered at the initial set up or global level (affecting all providers without negotiation) –

- *Rate Setting – How? Who?*
- *Payment – How? Who? When? How Fast?*
- *Eligibility – Who? How? What Process?*
- *Covered Services – Who Decides? Appeals?*
- *Contract Terms – Take It or Leave It Contract?*

(Where) Is There Any Negotiation?

- Many provider contract provisions may be "set in stone" by flow-down provisions
- Sources of flow-down provisions
  - Federal statutes
  - CMS regulations on managed care
  - Federal provider regulations
  - Contract Risk Agreement
- Negotiation of and Provisions in the Contract Risk Agreement or Similar document becomes extremely important in the development of Medicaid MC plan



The "Balance" of Power

- Health Plan gets leverage if it can selectively contract
- **A Provider draws its strength from the maximum value it can deliver to the MC system and its ability to deliver solutions to problems efficiently**
- Health Plan network access may be helpful if there is a geographic "hole" or hurtful if there is a "glut"
- Health Plans have strong incentive to contract with LTSS providers because such providers can reduce cost by replacing hospitalization, long term care and other forms of expensive care
- For Medicaid, the state's interests is less involvement and predictable costs without loss of quality

Contracting Basis

- Contracting Basics
- Facilities should try to enter into a specially negotiated contract rather than relying on the form contract provided by the Medicaid Managed Care Organization("MCO").
- Clarity is important:
- Make sure the contractual language is clear.
- Define important terms.
- Facilities should make sure they have the complete contract, including all documents to which the contract makes references.
- **READ AND UNDERSTAND.**

Negotiating Managed Care Contracts

- LTSS's provider must educate itself about managed care contracts and utilize strategies to maximize its effectiveness when negotiating with MCOs
- Consider the use of outside financial, legal and other professionals if that expertise does not exist in-house

Homework – Before You Start !!

1. Before contracting, run at least a 12 month analysis on existing client and cost data
2. Costs (how does it affect costs and what are internal “soft” costs to participate?)
3. Cash flow
4. Census (how do clients move in/out?)
5. Compliance (Regulatory requirements, liability)
6. Care (how does the program help to deliver care?)
7. Satisfaction – clients/staff/other providers/families
8. **QUALITY DATA TO SHOW VALUE!!!!**

Pre-Contract Diligence

- **Objectives:** Be sure to outline objectives when entering into particular contractual arrangement
- **Leverage:** Objectively evaluate your facility's negotiating strength in each set of contract negotiations
- Remember that though an MCO draws leverage from its ability to selectively contract, there are several ways providers can maintain negotiating power

Pre-Contract Diligence

- Providers should investigate a payor's history, creditworthiness, financial resources, and reputation
- Issues to look for:
  - Failure to pay claims in a timely manner
  - Failure to produce accurate financial statements in a timely manner
  - Loss of personnel/high employee turnover
  - Unjustified claim denials
  - High complaint volume

Negotiating Strategy - Leverage

- If there are few LTSS providers in your area, the Health Plan will have a much greater need to contract with you
- Health Plans have strong incentive to contract with LTSS providers because such providers can reduce cost by replacing hospitalization and other forms of expensive care
- **How can your organization affect a Health Plan's overall costs and efficiencies?**
  - **Sell! Sell! Sell!**

Clarity & Completeness

- Providers should try to enter into a specially negotiated contract rather than relying on the form contract provided by the MCO
- Make sure the contractual language is easy to understand and is not subject to ambiguity, unless in your favor
- Define important terms
- Providers should make sure it has the complete contract, including all documents to which the contract makes reference

Important Contract Terms

Billing/Payment

- Billing Format and Claims Submission - The contract should specify a billing format to be used by both parties, or at least state that the parties will mutually agree upon a billing format
- Denial of Payment – Try to limit retroactive denials based on lack of authorization or utilization review
- Prompt Pay – How fast does the MCO pay and what happens when they do not comply? Late fee, interest, etc.
- Overpayment – What is facility required to do?

Medicaid MC Payment Method

- Medicaid Managed LTC
  - Often a statutory rate framework and/or rates set by State not Plans
  - Legislation may limit plan negotiation
  - Medicaid Rates
    - Often a less robust payment bundle
    - Harder to vary costs / rates within per diem
    - Risk sharing can be more difficult in some cases

Pre-Authorization

- Contract should state what approvals and authorizations are needed prior to admission
- Providers should only be required to use “best efforts” to obtain authorization

Reimbursement and Payment - 1

- Payment Methodology and Source
  - There are various payment methods and structures
  - Negotiates for payment methods that are reasonable and consistent
  - If fixed, there should be an affirmative statement that payment is according to the agreed upon rate schedule
  - If risk sharing, what are the terms and conditions of bonuses and incentives?

Reimbursement and Payment - 2

- Billing and Prompt Payment
  - The contract should specify a billing format to be used by both parties, or at least state that the parties will mutually agree upon a billing format
- Denial of Payment
  - A facility should avoid or limit provisions that allow the MCO to retroactively deny payment based on lack of authorization or utilization review

Term and Termination

Term and Termination

- Review the term and termination section closely
- Mutuality for each side's needs is the key
- What triggers involuntary termination
  - Breach for non-payment, slow payment
  - Regulatory or quality considerations
- Consider the length of term and choose what makes sense for the providers' needs, but understand the needs of the MCO to have and keep a viable network
- Ideally, the provider should try to negotiate for its right to terminate for any reason

Amendment/Modification

- Avoid provisions which allow the MCO to unilaterally modify the contract
- **Provider Manuals !!!**
- Be wary of “re-opener” clauses which allow a facility to reject MCO proposed changes but then trigger termination of contract

Other Important Items

- Notification
  - Plan Changes
  - Provider Changes (enforcement, CHOW, etc.)
- Provider and Enrollee Grievances
- Insurance and Indemnification
- Hold-Harmless Clauses (Enrollee)
- Provisions required by Federal law or regulations (Flow-down)
- Resolution of Contract Disputes/Arbitration

Notification

- The contract likely will incorporate various appendices and exhibits
  - Ensure there is a provision so that provider gets these new versions
- The MCO will want to be apprised of any changes in conditions or situations, especially any legal problems that may arise
  - The provider should negotiate for a notification limitation that only requires notification based on statutory requirements or documents as a matter of public law

Other Provisions

- Hold-Harmless Clauses
  - Most contracts have clauses which prevent the provider from charging the enrollee for services not covered under the enrollee's plan
- Maintenance and Release of Records; Confidentiality
  - Do you need a provision relative to HIPAA rules?
  - Data collection and transfer
- Amendments and Modifications
  - Avoid provisions which allow the MCO to unilaterally modify the contract
  - Be wary of "re-opener" clauses which allow a facility to reject MCO proposed changes but then trigger termination of contract

APPENDIX B

Further Materials Regarding Developing Networks

Antitrust Law Issues Regarding Network Formation

- Restraints on Trade (Sherman Act § 1)
  - "Every contract, combination … or conspiracy in restraint of trade"
- Monopolization (Sherman Act § 2)
  - "Monopoliza[tion], or attempt[s at] monopoliz[ation], or combin[ations] or conspir[acies] with any other person or persons, to monopolize" trade or commerce
- Unfair Methods of Competition & Unfair or Deceptive Acts or Practices (FTC Act § 5)
  - Encompasses Sherman Act and Clayton Act violations

Sherman Act § 1

(1) Agreement

Prohibits "every contract, combination … or conspiracy in restraint of trade"

(2) Unreasonable Restraint of Trade

What Constitutes an Agreement for Antitrust Purposes

- A restraint on trade without an agreement does not violate Sherman Act § 1
- Solo Conduct is Permitted
  - Includes conduct of parent and its wholly owned subsidiary (constitute a "single enterprise")
- Parallel Conduct
  - Parallel conduct alone does not violate § 1
  - But, may reflect unwritten/implied agreement
    - Parallel conduct prompted by a unilateral offer suggests acceptance of the offer by performance
    - E.g., circulation of pricing information followed by parallel action

Joint Ventures and Further Antitrust Considerations

- **Integration is important because activities of joint ventures often would be *per se* illegal absent significant integration**
  - Price fixing
  - Boycotts
  - Market division
- **Activities otherwise *per se* illegal is protected if ancillary to purposes of joint venture**
- **Bigger risks often in operations of joint venture**
- **Important to avoid "spillover collusion":** agreements, or information sharing, related to markets where continue to compete

Examples of Clinical Integration

- Systems to establish goals relating to quality and appropriate utilization of services by participants;
- Regular evaluation of both individual participants' and networks' aggregate performance with respect to those goals;
- Modifying the participants actual practices where necessary based on those evaluations.
- Engaging in case management, preauthorization of some services, and concurrent and retrospective review;
- Development of practice standards and protocols to govern treatment and utilization of services, and actively review the care rendered by each participant in light of those standards and protocols;
- Significant investment of capital to purchase the information systems necessary to gather aggregate and individual data on the cost, quality and nature of services provided or ordered by the participants, in order to measure performance of the group and individual participants against cost and quality benchmarks and to monitor patient satisfaction.

Messenger Model: Suspect Activities - 1

- Messenger coordinates multiple provider responses to payer proposals.
- Messenger shares intentions of providers with other providers.
- Messenger expresses opinion on payer rates and terms.
- The messenger collectively negotiates for providers.
- The messenger is given the discretion to report payer proposals to the provider or reject without presenting to the provider.

Messenger Model: Suspect Activities - 2

- Meetings amongst groups of network providers and messenger to discuss rates.
- Messenger encouraging providers to cancel contracts and enter into more favorable contracts negotiated by the messenger.
- Messenger refusal to convey payer proposals to provider, or provider proposals to payer.

Officers/Staff of Network Entity

- Newco could have one or more staff that would be direct employees of Newco
- Some staff may be employed part-time by both managing member and Newco, leased from managing member or may be former employees of managing member
- To maintain confidentiality, Newco staff would not share participants' independent pricing and pricing terms with participating Members, managing member staff that were employed by Newco would not be involved in any network provider's programs

Network Programs and Procedures

- **Referral Procedures** – Network may establish procedures for appropriate referrals by Community Providers to other providers when appropriate.
- **Quality Assurance Standards** – Network may establish quality metrics addressing eligibility determinations, care management determinations, operational protocols and procedures, record keeping requirements, appropriate staffing etc.
- **Utilization Review Program** – Network may establish a utilization review program.
- **Credentialing and Licensing** – Network may establish credentialing and licensing standards.
- **Grievance Procedures**
- **Medical and Administrative Records and Health Information Interoperability**
  - Address authority to access medical records
  - Build out of HIT infrastructure

Governance/Other Owners' Approval Rights

- Entering into or approving contracts over certain amounts
- Approving bankruptcy or similar actions regarding Newco
- Amending the Operating Agreement or Articles of Organization
- Approving commencement of or settlement of litigation
- Approving a change in the nature or expansion of business to be operated by Newco
- Approving material modifications to Network Policies and Procedures
- Approving material modifications to the form Participating Provider Agreement
- Approving Newco's annual operating budget