MANAGED CARE – RIGHT TO CONTRACT AND NEGOTIATING KEY PROVISIONS

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FACE
CHALLENGES
CONFIDENTLY

INTRODUCTION

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INTRODUCTION

- Historically, DME suppliers have taken care of Medicare patients and have billed CMS directly. This is known as "Medicare fee-for-service" (or "Medicare FFS").
- Also, historically, suppliers have taken care of state Medicaid patients and have billed state Medicaid programs directly ("Medicaid FFS").
- All of this is changing.
- Today, about 35% of Medicare patients are covered by Medicare Managed Care Plans (commonly known as "Medicare Advantage Plans") and about 70% of Medicaid patients are covered by Medicaid Managed Care Plans. These percentages are increasing

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INTRODUCTION

- Here is how a Medicare Advantage Plan works:
  - Insurance company will create (and own) a subsidiary corporation (or LLC) that will be the "Plan." The Plan will sign a contract with CMS.
  - The contract will say that the Plan will be responsible for those Medicare patients in e.g., Ohio, who sign up with the Plan's Medicare Advantage Plan.
  - The Plan will market to Medicare beneficiaries in the state and persuade them to "sign up" with the Plan...as opposed to staying with Medicare FFS or signing up with a competing Medicare Advantage Plan.

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INTRODUCTION

- Here is how a Medicare Advantage Plan works (cont.):
  - The Plan will create a "network" of health care providers: hospitals, physicians, labs, DME suppliers, home health agencies, etc. A provider will join the network by signing a contract with the Plan.
  - When a Medicare patient sees a Plan provider, then the Plan provider will bill (and receive payment from) the Plan. The Plan, in turn, receives payment from CMS.
  - The Plan's goal is for the money it receives from

INTRODUCTION

- A Medicaid Managed Care Plan works essentially the same way
  - Sparsely populated states may have only one, or just a couple, Medicaid Managed Care Plan.
  - More populous states will have a number of Plans that compete with each other.

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CHALLENGES FACING SUPPLIERS

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CHALLENGES FACING SUPPLIERS

- As DME suppliers are being drawn into the Medicare and Medicaid Managed Care arenas, they are facing a number of challenges:
  - A Plan may be "closed" to new DME suppliers. Essentially, the Plan says to the supplier that wants to be admitted into the Plan's network: "We have enough DME suppliers to service our "covered lives. We don't need you in our network."
  - A Plan will announce on e.g., 3/1/21 that (i) it has been paying $100 for Product A, (ii) it should have been paying only $80 for Product A, and (iii) therefore, the Plan will retroactively recoup the

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CHALLENGES FACING SUPPLIERS

- Challenges (cont.)
  - The Plan's contract will state that the supplier must take "assignment" from the covered life (i.e., the supplier cannot sell an item to the covered life for cash).
  - The Plan's contract will state that the supplier must adhere to the Plan's manuals, policies and other written guidelines as amended from time to time. Said another way, the supplier must adhere to "outside" documents that are not part of the contract.
  - The Plan's contract will state that the Plan can amend the contract from time-to-time (including modifying the reimbursement) upon giving written

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CHALLENGES FACING SUPPLIERS

- Challenges (cont.)
  - The Plan's contract will allow the Plan to terminate the contract without cause upon giving prior written notice to the supplier.
  - The Plan will enter into a "sole source" contract with ABC Medical Equipment, Inc. This means that the Plan's covered lives can only secure DME from ABC.

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PREPARING FOR THE NEGOTIATION PROCESS

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PREPARING FOR THE NEGOTIATION PROCESS

- In entering into contract negotiations with a Plan, the DME supplier should take several steps to improve its position under the contract.
- The supplier should evaluate its reasons for entering into the contract.
  - For example, does the supplier really need the contract? Is the supplier discovering that so many of its existing and prospective patients are covered by the Plan that it is important for the supplier to secure the contract?
  - The supplier should have a sense of its strengths and weaknesses, conditions influencing the market, and the competition. In doing so, the supplier will have an understanding of how strong or how weak

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PREPARING FOR THE NEGOTIATION PROCESS

- Pre-negotiation steps (cont.):
  - Find out information about the Plan. For example, the supplier should attempt to determine how many other DME suppliers are already in the Plan's network or whether the Plan intends to expand.
  - The supplier should have an understanding of the Plan's market position and how it handles contracts with other health care providers/suppliers.
  - The supplier should seek to determine if the Plan is financially solvent.
  - A telling fact about any Plan is its age and its market share.
  - Obtain a copy of the contract proposed by the Plan, as well as collateral documents incorporated by reference in the contract, and review them carefully.

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PREPARING FOR THE NEGOTIATION PROCESS

- Pre-negotiation steps (cont.)
  - Prepare a list of questions to ask the Plan regarding the contract including:
    - The amount of time the current contract form has been used;
    - The terms that are most commonly modified in the contract; and
    - Any significant modifications made to the form contract within the past 12 to 18 months.
  - By taking these steps, the supplier will have the basic information necessary to review the contract and prepare a list of issues to be addressed during

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UNDERSTANDING THE CURRENT LEGAL CLIMATE

- The supplier should determine whether its state has an "any-willing provider" law . . . and if it does, whether such law extends to DME suppliers.
- If the supplier desires to join with other suppliers in order to "negotiate as a group," then the supplier should have an understanding of antitrust laws. For example, such laws prohibit suppliers from engaging in "price fixing" or "restraint of trade" or "market allocation."

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NEGOTIATING CONTRACT TERMS

- The supplier's ability to negotiate specific terms depends on the amount of leverage it has in its market.
- Suppliers need to educate Plans concerning the suppliers' costs in providing the products and services required under the contract.
- Before the supplier can do this, however, it must know its costs.

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KEY CONTRACT PROVISIONS

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DEFINITIONS

- Important provisions in a contract are the definitions because they set forth the "rules of the game" for how the contract will be implemented.

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IDENTIFICATION OF THE PARTIES

- Most Plans identify DME suppliers by tax identification numbers.
- Subsidiaries or affiliated entities need to be listed as parties to the contract or enter into separate contracts with the Plan if they are to be a part of the Plan.

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COVERED SERVICES

- "Covered services" should be defined specifically and any products and services that the supplier will not be providing eliminated from the contract.

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MEDICAL NECESSITY

- "Medical Necessity" needs to be defined in the contract, with specific procedures for determining medical necessity and for bearing the risk of error if the products/services are provided and later determined not to have been medically necessary.
  - For example, a BCBS contract defines "Subscriber" has "any person with whom [BCBS] has entered into an agreement to provide coverage." The contact defines "Subscriber Contract" has the contract under which BCBS "or the Plan Sponsor provided benefits to Subscribers for Health Services." The contract then states that "Medical Necessity" has the meaning as defined in the Subscriber Contract - that - in the judgment of BCBS's Utilization Review Process, the DME is appropriate and is consistent with the diagnosis and treatment plan and that, in accordance with accepted medical standards in the State of _____, cannot be omitted without adversely affecting the subscriber's condition.

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HOLD HARMLESS

- This concept is seen most often in its benign form, that is, where the supplier agrees to hold a covered life harmless and not seek reimbursement directly from him or her for covered services rendered.
  - This is a fairly standard and nonnegotiable provision in managed care contracts.
  - This is where the definition of "covered services" is critical.
- Suppliers should watch for provisions that require them to hold the Plan harmless from findings of supplier negligence arising from the supplier's compliance with the Plan's policies.

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NO-DISPARAGEMENT

- These are basically "no slander" clauses under which the supplier agrees not to disparage the Plan.
  - Unfortunately, "disparagement" is almost never defined.
  - Consequently, Plans read this term broadly.

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PASSIVE AMENDMENT

- Be aware of passive amendment provisions that state that amendments to the contract offered in writing to the supplier, that are not expressly rejected in writing by the supplier within a certain time frame, are automatically deemed accepted by the supplier.

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PASSIVE AMENDMENT

- In the managed care arena, passive amendment provisions are most often used to add new Plan products and payment schedules when the supplier has agreed in advance to accept all new products meeting certain criteria.
  - For example, a BCBS contract states: "The Agreement may be modified and/or amended at any time by Blue Cross upon at least forty five (45) days' prior written notice to the Provider; provided, however, that forty five (45) days' advance written notice shall not be required in those circumstances when Blue Cross modifies the fee schedule to correct errors or omissions or to reflect state or federal regulatory requirements, in which case Blue Cross shall provide as much advance notice as is reasonably practical. In the event of any amendment by Blue Cross, Provider shall have 45 days to reject the amendment and terminate the

WAIVER OF LEGAL RIGHTS AND REMEDIES

- Under the guise of expedience and efficiency, many contracts specify that, in the event of a dispute between the parties, the matter will be resolved through mandatory arbitration in lieu of litigation.
- Suppliers should be sure that in relinquishing their legal rights to enforce the contract through certain mechanisms, those rights are waived only for defined actions under the contract, such as failure to pay, and not for all disputes that could arise.

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INCORPORATION OF COLLATERAL DOCUMENTS

- Many important terms are attached to the contract or are incorporated by reference in exhibits, schedules and handbooks.
- Typically, utilization review, quality assurance programs, payment terms and provider due-process rights are contained in collateral documents.

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INCORPORATION OF COLLATERAL DOCUMENTS

- The Plan will argue that the terms of the contract do not articulate the mutual promises of the parties, but that the contract instead includes what is written in the contract as modified by the more specific terms in the Plan's manuals and other collateral documents.
- The Plan will claim that because it has the right to modify its manuals during the term of the contract, it also has the right to modify the contract itself.

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INCORPORATION OF COLLATERAL DOCUMENTS

- For example, an MVP Health Plan contract states: "Ancillary Provider agrees to...be bound and abide by all of MVP's programs, protocols, rules and regulations including, without limitation, MVP's quality improvement program, credentialing process, peer review systems, member grievance system and utilization management program."
- As another example, a BCBS contract states: "To promote efficiency and network consistency, Blue Cross shall have the right at any time to issue Provider Bulletins pursuant to this Agreement for the purpose of implementing certain policies, procedures and requirements relating to this Agreement...and Provider shall comply with such Provider Bulletins....Blue Cross shall provide Provider with at least forty five (45) days' advance written notice from date of publication on [link to BCBS's website] of any new Provider Bulletins, unless such Provider Bulletins are issued to comply with a state for federal regulatory or accreditation requirement or to address only minor administrative or operational clarifications, as reasonably determined by Blue

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SET-OFF PROVISIONS

- A set-off provision allows the Plan to control the money during a dispute. It allows the Plan to withhold disputed amounts from future payments to the supplier.
  - Because these provisions allow the Plan to make a unilateral decision, they are susceptible to abuse.
  - The supplier should attempt to have set-off provisions removed from the contract.

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SET-OFF PROVISIONS

- On the other hand, because set-off provisions can serve a valid purpose when they are exercised in good faith as a means to correct true mistakes, completely eliminating them may not be possible.
  - The next best option is to build limitations and protections into set-off provisions.
  - For example, an Amerigroup contract states: "Amerigroup shall be entitled to offset and recoup an amount equal to any overpayment or improper payments made by Amerigroup to Provider against any payments due and payable by Amerigroup to Provider under this Agreement...."

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MISSING OR INADEQUATE PROVISIONS

- Frequently, the interpretation of a contract hinges on a single word or phrase that has no defined meaning.
- This may occur simply because the parties do not consider the potentially competing definitions of a specific term, or because the Plan chooses to define a term in a way that is advantageous to it.

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EVERGREEN CLAUSES

- An evergreen clause automatically renews the contract for another term if the contract is not terminated within a specified notice period prior to the end of the current year.
- This clause usually serves no rational purpose and is difficult to manage.
- Such a clause actually serves as a disincentive for the parties to regularly renegotiate the contract in the ordinary course of business.
- An evergreen clause is undesirable because a supplier that fails to provide notice of its intent to renegotiate within the specified time is obligated to provide services and products for another year at what may become below-market rates.

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EVERGREEN CLAUSES

- Another pitfall occurs when the supplier engages in good faith negotiations that continue past the date by which the termination notice is required, thinking that it would be inappropriate
  - For example, a BCBS contract states: "[T]his Agreement shall...automatically renew for each subsequent renewal term...."

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REMEDY FOR UNEXCUSED DELAY IN PAYMENT

- It is reasonable to negotiate a contractual provision obligating the Plan to pay interest if payment is not made within a specified period after the receipt of a clean claim.
- State prompt-pay laws have created a similar remedy by requiring a Plan to pay a specified rate of interest if payment is not made within a certain number of days of receiving a "clean" or "complete" claim.
- However, these laws often give definitions of "clean" and "complete" claims that are too vague to be of practical assistance in enforcing the prompt-pay penalty.
- Suppliers should work with the Plans to specifically define "complete claim" in the context of what that Plan expects, consistent with the applicable state's prompt-pay regulations.

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PAYMENT FORFEITURE FOR LATE CLAIMS

- Plans want claims to be submitted in a timely fashion so that the Plans can better manage their accounts. However, Plans should not be allowed to require suppliers to forfeit all payments on claims that miss the deadline.
  - To avoid such disputes, suppliers should attempt to negotiate a more reasonable incentive for the prompt submission of claims.

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AUDIT DEFINITIONS

- The contract should define the scope of the Plan's audit rights.
- The most common scope of an audit is one that determines whether all products and services appear on the bill and whether the supplier's records support the bill.
- Plans often try to expand this scope in an attempt to second guess medical necessity issues through an audit.
- Although it is appropriate for a Plan to have a role in determining medical necessity, these issues are best addressed through the contract's utilization review provisions, where the parties can specify standards and procedures.

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AUDIT DEFINITIONS

- Plans also perform audits as a way of challenging a provider's rates.
  - This practice is inappropriate because rates are addressed separately in the contract, and no supplier intends to give a Plan a unilateral right to revise its rates through an audit.
- The time limits within which an audit can be performed should be specified.

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ATTORNEY'S FEES

- Plans may include in the contract a clause requiring the losing party in a dispute to pay the attorney's fees of the winning party.
- Plans have a greater incentive and greater resources with which to litigate or arbitrate a dispute.
- The added risk that the Plan may have to pay the supplier's attorney's fees is usually not material in the Plan's calculations.
- For suppliers, however, the added risk of paying attorney's fees may act as a disincentive to pursue the matter.

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DISCRETION LEFT TO THE PLAN

- An obvious dangerous clause is one that allows the Plan to define a term of the contract unilaterally.
- It sometimes may be necessary to leave some terms of the contract to the Plan's discretion, but these terms should relate to minor issues only.
- Even then, the Plan’s discretion should be severely limited by identifying standards under which it can be exercised.

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INSURANCE AND INDEMNIFICATION

- Each party should carry its own professional and general liability insurance for its own acts or omissions.
- Suppliers should only be required to insure against their own liability and not the liability of the Plan.
- Avoid insurance or indemnification provisions that shift the risk of loss for the Plan's acts to the supplier.

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CLAIMS PROCESSING

- Claims processing is one of the most routinely disputed provisions of contracts between Plans and DME suppliers.
- At the source of many of these conflicts are state laws requiring prompt payment of "clean claims" submitted to Plans.
- There are two key time limits that are of specific concern to suppliers in claims processing:
  - First, the contract will contain a clause requiring the supplier to submit a claim within a certain time period after provision of services or products in order to be paid.
  - Secondly, the contract should contain a clause requiring the Plan to pay a clean claim within a certain amount of time

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CLAIMS PROCESSING

- The supplier should request that the contract discuss what constitutes a clean claim by describing the information required and discussing a method for resolving disagreements between the parties.
- The contract should also include specific penalties such as late payment penalties, interest payments, and, in some cases, termination of the contract in the event of continued delay or non-payment.
  - For example, an Amerigroup contract states that a "clean claim" is a claim received by Amerigroup for adjudication, in a nationally accepted format in compliance with standard coding guidelines, and which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by Amerigroup."

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MARKETING

- The supplier should request the right to review all marketing materials referring to the provider before they are used by the payor.
- Conversely, the contract may impose restrictions on how the supplier can market to, or otherwise communicate with, the Plan's covered lives. For example:
  - The contract may require the supplier to "obtain Payor's and HMO's approval for Covered Person communications ..."
  - The contract might contain the following provision: "Provider shall not conduct marketing activities unless expressly approved in writing and only after all training and credentialing required under the

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MARKETING

- The contract between CMS (or the state Medicaid program) and the Plan might define "Marketing" as "any written or oral communication from [MCO] or its representative that can reasonably be interpreted as intended to influence a Participant to enroll, not to enroll, or to disenroll from a health care delivery system."
  - Even though the definition set out in the preceding sub-bullet does not specifically apply to actions by suppliers, it may be construed to be applicable to the definition of "marketing" set out in the contract between the Plan and the supplier.
  - As such, there is a risk that a communication by a supplier notifying patients that the supplier has terminated its contract with the Plan and providing patients with a list of other Plans with which the supplier remains in network, may be viewed as a

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MARKETING

- Separate and apart from the supplier's contractual obligations, guidance regarding communications with patients may be set out, e.g., in the Medicaid program's *Managed Care Manual for Medicaid Providers* ("Manual").
- The Manual may set out a process for suppliers to "educate" their patients about their choices between the different Plans.
  - For example, the Manual may state that "[I]f a Provider chooses to educate [its] patient...[the Provider and its staff] must ensure that the patient is aware of all plan choices and use materials approved by the Department for this education."
  - It is not uncommon for a state Medicaid program to publish a flyer/template for suppliers to utilize when communicating with their patients. The template may require the supplier to identify all Plans with which it is contracted and also direct the patient to the Medicaid program's Participant Enrollment Services in order

MARKETING

- The state Medicaid program may give the supplier the option to include a preferential statement regarding a certain Plan in the flyer/letter if the preference is a benefit to the patient, and not just a benefit to the supplier.
- If the supplier is given such an option, then it is likely that the flyer/letter must be submitted for approval by the preferred Plan and the state Medicaid program.
- The Medicaid program will likely instruct suppliers not to include any false or disparaging statements regarding Plans.

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MARKETING

- The Manual may prohibit the supplier from contacting patients by telephone to (i) inform them that the supplier has terminated its agreement with ABC Plan and (ii) suggest that the patient switch out of the ABC Plan.
- For example, the Health Plan Outreach Guidelines in a state may prohibit "face-to-face outreach by the Health Plan directed at participants or potential enrollees, including direct or indirect door-to-door contact, telephone contact, or other cold-call activities …"
  - While the above language applies to telephone calls by the Plan, the state Medicaid program may apply the restrictions to suppliers.

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MARKETING

- Assume that a supplier terminates its contact with ABC Plan and desires to direct its patients to XYZ Plan. Assume that the supplier desires to run Facebook adds that inform patients of the termination and the desire by the supplier that the patients switch Plans.
- The supplier needs to carefully word such an ad.
- The ad cannot be misleading. For example, if the ad says that ABC Plan is reducing patient choice, then such a statement may be misleading. ABC Plan might argue that the supplier can remain in network with ABC Plan so long as the supplier is willing to accept the lower reimbursement.
- In addition, the supplier may be required to obtain approval of the Facebook ad by the state Medicaid program and ABC Plan.
- The Manual may require the supplier to use materials (intended to educate patients) that have received the prior approval by the state Medicaid program.
- Lastly, it is important that the Facebook ad not be looked at as "tortious interference" with ABC Plan's business.

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MARKETING

- A properly-worded Facebook ad might say something like the following: "You have a choice in your Medicaid Managed Care Plan. If you have respiratory problems, diabetes, or use oxygen, incontinence products or a wheelchair, please make sure that your provider of choice for medical equipment and supplies is in-network with the Medicaid Managed Care Plan you choose."
  - By broadly stating facts not specifically identifying ABC Plan, this language should eliminate the risk of ABC Plan objecting to the ad on the grounds that it is misleading or defamatory.
  - In addition, as the ad does not specifically identify ABC Plan and is not specifically targeted to ABC Plan members, it significantly reduces the risk of a tortious interference claim.

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MARKETING

- Assume the supplier will terminate its contract with ABC Plan because the supplier cannot accept ABC Plan's reimbursement cuts.
- A properly worded letter from the supplier to its ABC Plan patients might say something like the following:
  - "The purpose of this letter is to inform you of an upcoming change in the provision of our products and services. On [date], we will no longer be contracted with ABC Plan and will not be able to continue to service your durable medical equipment or medical supply needs under the ABC Plan."
  - "The [name of state] Medicaid program requires most individuals with a Medicaid card to pick a health plan for their care coordination services. The health plan you pick will provide you with all of your health care needs and help coordinate your care."
  - "The health plans you may be required to pick go by the following names: (i) _____ and (ii) _____."
  - "We provide health care to the following population: (i) Family Health Plans; (ii) Seniors and Persons with Disabilities; and (iii) ACA Adults."
  - "We also contract with the following Health Plans to provide services to our patients: (i) Health Plan 1; (ii) Health Plan 2; (iii) Health Plan 3; (iv) Health Plan 4; (v) Health Plan 5; (vi) Health Plan 6; and

DOCUMENTATION REVIEW

- If a contract requires that a supplier adhere to the Plan's policies and procedures, the supplier must be allowed to review them prior to executing the contract.

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MEDICAL RECORDS

- The HIPAA privacy standards allow for broad sharing of information between suppliers and Plans for the purposes of receiving payment for services rendered.
- No business associate language is required.

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REIMBURSEMENT

- The most important clause in a contract is the reimbursement provision.
- Contracts should include a provision to renegotiate the reimbursement provision based on defined events.
- Suppliers should be realistically self-critical in evaluating their ability to fulfill the contract terms.
- The primary risk to the supplier lies in whether it understands clearly enough its costs to provide the products and services for which the supplier is contracting.
- Suppliers should carefully analyze the reimbursement provisions to determine whether the reimbursement amounts listed provide adequate compensation for the

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TERM

- Suppliers may wish to enter into a contract for an initial term of one year with a longer renewal term so that they can have flexibility in addressing any shortfalls to the fee schedules that occur during the initial year.
- Suppliers should closely track contract renewal dates, as well as deadlines for modification.

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TERMINATION

- Specifying the factors that may lead to termination, such as the failure of the Plan to make payment, is vital.
- Post-termination obligations are important. Regardless of the reason for the termination, the obligations to continue treating the Plan's members should be clear, defined and time-limited.
  - For example, a BCBS contract states: "This Agreement may be terminated without cause by a Party upon prior written notice to the other Party with termination to become effective 130 days after receipt of written notice. If the Agreement is so terminated, Blue Cross, at its discretion, may extend the terms of the current Agreement for a period of up to an additional 180 days, to allow Blue Cross proper notification of Subscribers and

ONEROUS TERMINATION PROVISIONS

- Suppliers that wish to terminate their relationship with a Plan have less leverage if they have agreed to onerous termination provisions.
- If the cost of contract termination is too high for the supplier, the supplier will have less leverage with which to press for fair and reasonable terms in negotiations to extend or replace the contract.

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SUBCONTRACTING

- A DME supplier, that is a party to a contract, may desire to subcontract out certain responsibilities to another supplier. Before doing so, the supplier (contracted with the Plan) should determine if the contract addresses subcontracting.
  - For example, a BCBS contract states: "All subcontracts of Provider under this Agreement must be in writing. All subcontracts of Provider are subject to Blue Cross review and approval, upon request of Blue Cross. All subcontractors of Provider shall meet all applicable terms and conditions of this Agreement. Subcontracts shall not abrogate or alter Provider's responsibilities under this Agreement."
  - For example, an Amerigroup contract states: "Unless otherwise approved by Amerigroup in writing, Provider shall not use any subcontracted provider to furnish

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ASSIGNMENT

- Assume that a supplier (that is contracted with a Plan) sells its assets to another supplier and, in so doing, desires to transfer (or "assign") its contract to the purchaser. The seller must first review the contract to determine if it allows assignment.
  - For example, a BCBS contract states: "This Agreement...shall not be assigned or transferred by Provider without the written consent of Blue Cross, such consent not to be unreasonably withheld."

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APPEALS

- Before the supplier signs a contract, the supplier should determine what the contract says about the Provider's appeal rights.
  - For example, a BCBS contract states: "The Provider and Subscriber shall have the right to appeal Utilization Review decisions through Blue Cross' Utilization Review Process as set forth in the Provider Policy & Procedure Manual."

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HOME SET-UPS

- The DME supplier needs to determine is the contract requires the supplier to conduct home set-ups and training.
  - For example, a BCBS contract states: “When appropriate or requested by the Subscriber, Provider will set up the DME at the Subscriber’s home and provider training to the Subscriber and his or her family.”

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VOLUNTARY REPAYMENTS

- Some contracts will impose on the supplier the affirmative obligation to voluntarily repay claims that should never have been paid to the supplier in the first place.
  - For example, a BCBS contract states: "Provider shall promptly report and return overpayment of any kind to Blue Cross."

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COLLECTION OF COPAYMENTS

- Many contracts expressly require the supplier to make a "good faith" effort to collect copayments and deductibles.
  - For example, a BCBS contract states: "Provider agrees to make a good faith effort to collect any deductible, coinsurance, and/or copayment amounts due from Subscribers. This provision shall not prohibit Provider from collecting a lesser amount on individual hardship cases as determined by Provider."

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USING ANOTHER SUPPLIER'S THIRD PARTY PAYER CONTRACT

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USING ANOTHER SUPPLIER'S THIRD PARTY PAYER CONTRACT

- A challenge faced by many DME suppliers is that Plans have "closed panels." This means that the Plan tells the DME supplier: "We have enough DME suppliers on our provider/supplier panel. We don't need you. Therefore, we will not sign a contract with you."
- The end result for the DME supplier is that if a patient wants to obtain a product from the DME supplier, and if the patient is covered by the contract for which the DME supplier is not on the panel, then the DME supplier must turn the patient away…unless, of course, the patient is willing to pay cash to the DME supplier without getting reimbursed by the Plan.

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USING ANOTHER SUPPLIER'S THIRD PARTY PAYER CONTRACT

- As a "workaround," the DME supplier may want to enter into an arrangement with another DME supplier to gain access to the other DME supplier's contract. For example, the two suppliers may want to do the following:
  - Supplier A is a party to Contract 1. Supplier B is not a party to Contract 1.
  - When a patient under Contract 1 wants to purchase a product from Supplier B, then Supplier B will take care of the patient.
  - Supplier B will (i) handle intake, assessment and coordination of care (collectively referred to as "intake"), (ii) deliver and set up the equipment, and (iii) handle the subsequent maintenance and repairs.
  - Supplier A will submit a claim under Contract 1. Upon receipt of payment under Contract 1, Supplier A will (i) pay a large percentage (e.g., 92%) to Supplier B and (ii) retain the balance.

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USING ANOTHER SUPPLIER'S THIRD PARTY PAYER CONTRACT

- The problem with this arrangement is that it likely violates the federal anti-kickback statute ("Federal AKS"), the federal False Claims Act ("Federal FCA"), and their state counterparts. Here are how the Federal AKS and Federal FCA may come into the picture:
  - **Federal AKS –** This statute makes it a felony for (i) Supplier A to give anything of value in exchange for receiving the referral of a patient covered by a government health care program and (ii) Supplier B to receive anything of value in exchange for referring (or arranging for the referral of) a patient covered by a government health care program. In the eyes of the Plan, the "supplier" is Supplier A: it is the party to the contract and it is billing and collecting under the contract. The kickback issue arises because (i) Supplier B is referring or arranging for the referral of the patient to Supplier A and (ii) Supplier A is, in turn, remitting e.g., 92% of the payment to Supplier

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USING ANOTHER SUPPLIER'S THIRD PARTY PAYER CONTRACT

- **Federal FCA –** This statute prohibits Supplier A from submitting "false claims"…and Supplier B cannot conspire (or collaborate) with Supplier A for the submission of false claims. When Supplier A submits a claim to the Plan, Supplier A is representing that it is the supplier…that it took care of the patient and, therefore, deserves to be paid. In fact, this is not the case. The *true* supplier is Supplier B; it is the entity that does all of the work. All Supplier A does is submit a claim under the contract. Hence, the claim submitted is a false claim. And Supplier B will have collaborated with Supplier A in the submission of the false claim.

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USING ANOTHER SUPPLIER'S THIRD PARTY PAYER CONTRACT

- So now that we have talked about what Supplier A and Supplier B cannot do, let us talk about what they *can* do. If Supplier A and Supplier B desire to enter into a Subcontract Agreement ("SA"), then here are the steps they should take:
  - **Review the Contract -** The parties need to review Supplier A's contract to determine if it addresses subcontract arrangements. The contract may say nothing about whether or not Supplier A can subcontract out its responsibilities to Supplier B. If the contract *is* silent, then in order to avoid problems under the Federal AKS and Federal FCA, the SA should be structured as set out hereafter. On the other end of the spectrum, the contract may prohibit Supplier A from subcontracting out its services. The contract may very well take the middle road and provide for one of the following: (i) Supplier A can subcontract out its services but must first notify the Plan who the subcontractor will be; (ii)

USING ANOTHER SUPPLIER'S THIRD PARTY PAYER CONTRACT

- **Supplier A Must Retain a Level of Operational Responsibilities and Financial Risk –** So that it can credibly assert that it is the "supplier," Supplier A must have a level of operational responsibilities and financial risk. For example, Supplier A needs to handle the intake. This means that Supplier A must determine if the patient qualifies for coverage under the contract. Supplier B can gather information and documents and forward them to Supplier A…but it is Supplier A, not Supplier B, that must determine if the patient is to receive the product. If the patient later has a maintenance/repair need, then he needs to call Supplier A; Supplier A can, in turn, direct Supplier B to handle the repair/maintenance. Further, Supplier A will be obligated to pay Supplier B regardless of whether or not the Plan pays Supplier A. In other words, Supplier A's obligation to pay Supplier B for its services is *absolute*.

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USING ANOTHER SUPPLIER'S THIRD PARTY PAYER CONTRACT

- **Inventory –** Under the SA, Supplier B will deliver the product to the patient "for and on behalf of Supplier A." At the time of delivery, title to the product needs to be in Supplier A's name. This can be accomplished in one of several ways: (i) Supplier A can purchase the inventory, take possession of it, and deliver it to Supplier B; (ii) Supplier A can purchase the inventory, *not* take possession of it, and direct the manufacturer to deliver the inventory (on behalf of Supplier A) to Supplier B; (iii) Supplier B can purchase the inventory; on a regular basis, Supplier A can purchase inventory from Supplier B and Supplier B can segregate Supplier A's inventory in Supplier B's warehouse; or (iv) Supplier B can purchase the inventory; when Supplier B is about to deliver the product to the patient's home, then title will transfer to

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USING ANOTHER SUPPLIER'S THIRD PARTY PAYER CONTRACT

- **Supplier B's Services –** The SA can provide that Supplier B's services include the following: (i) deliver the product to the patient, educate the patient on how to use the product, and set the product up for the patient; (ii) obtain information and documents from the patient and his physician and transmit them to Supplier A so that Supplier A can conduct the intake; and (iii) at the direction of Supplier A, provide maintenance and repair services to the patient. The labels on the products delivered to the patients need to reflect Supplier A.

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USING ANOTHER SUPPLIER'S THIRD PARTY PAYER CONTRACT

- **Flow of Money –** At the end of the day, Supplier B will be referring (or arranging for the referral of) patients to Supplier A…and Supplier A will be paying money to Supplier B. The most conservative course of action is as follows: (i) if Supplier A purchases inventory from Supplier B, then the purchase price must be fair market value ("FMV") and must be pursuant to a price list attached to the SA; and (ii) Supplier A pays fixed annual compensation (e.g., $48,000 over the next 12 months) to Supplier B in which such compensation is the FMV equivalent of Supplier B's services. If fixed annual compensation is not feasible, then a less conservative course of action is as follows: (i) if Supplier A purchases inventory from Supplier B, then the purchase price must be FMV and must be pursuant to a price list attached to the SA; and (ii) Supplier A pays a fixed fee per each unit of service provided by Supplier B, such compensation is the FMV equivalent of Supplier B's services, and the compensation is set out in a fee schedule attached to the SA. If the parties want to strengthen their position that the compensation paid to Supplier B is FMV,

CONTESTING REIMBURSEMENT CUTS AND SOLE SOURCE CONTRACTS IN THE MEDICAID ARENA

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INTRODUCTION

- It is no secret that the rolls of state Medicaid programs are swelling.
- As a result, the cost of providing health care to Medicaid beneficiaries is increasing exponentially. Money for this health care coverage comes from the federal government and comes from each state.
- As is the case with every aspect of health care, money is tight.
- Simply speaking, many (if not most) states cannot afford the increasing number of Medicaid beneficiaries.
- This is the proverbial "irresistible force meeting the immovable object."

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INTRODUCTION

- To meet this financial challenge, many state Medicaid programs are contracting with insurance companies that sponsor Plans.
- A goal of the Plan sponsor (the insurance company) is to generate a profit (i.e., the Plan will pay less money to the providers than what the state Medicaid program pays the Plan).
- The upside to the state Medicaid program is that contracting with Plans injects a degree of "certainty" into the Medicaid program's financial picture.

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INTRODUCTION

- That is, year-to-year, the Medicaid program has a good idea of what it will be spending.
- The Medicaid program will pay the Plans … and then let the Plans "sweat the details."
- While a number of criticisms can justifiably be levied against Medicaid FFS programs (i.e., bureaucratic, inefficient), a Medicaid FFS program cannot be accused of trying to "turn a profit."
- This is not the case with Plans.

INTRODUCTION

- At the end of the day, the goal of the Plan is for (i) the inflow of money from the Medicaid program to be (ii) greater than the outflow of money to providers.
- Said another way, an important goal of each Plan is to generate a profit.

INTRODUCTION

- In order to generate a profit, Plans are motivated to ratchet down reimbursement to providers.
- There are three primary ways for Plans to do this:
  - A Plan will reduce reimbursement to an almost unstainable level and providers can "take it or leave it."
  - A Plan will enter into a sole source contract with a DME supplier. The reimbursement to the sole source supplier will be low, but the supplier is willing to accept it because of the increased volume. In essence, the sole source supplier is granted a monopoly.
  - A goal of a Plan will be to end up in a sole source relationship but will "back door" its way into such a relationship. The Plan will reduce reimbursement so much that DME suppliers drop out…leaving the Plan's preferred supplier as the "last supplier standing."

INTRODUCTION

- Plans will get away with these actions unless the state Medicaid programs intervene.
- There are two things that state Medicaid programs do not want to happen:
  - First, they do care about their Medicaid beneficiaries; the state Medicaid programs do not want their beneficiaries to receive substandard care.
  - Second, state Medicaid programs do not want to be embarrassed. The last thing that a state Medicaid program wants to see is a report by Anderson Cooper (CNN) or Sean Hannity (Fox) about harm being done to Medicaid beneficiaries.

MEDICAID V. MCO PRIORITIES

- As previously discussed, a Plan's priority is to generate a profit. It wants to pay less to providers/suppliers than what the Plan is paid by the state Medicaid program. This profit incentive can result in the Plan accepting substandard products and services.
- On the other hand, the state Medicaid fee-for-service ("FFS") program may be inefficient, but it is focused on the health of its beneficiaries. The Medicaid program is not influenced by profits.

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MEDICAID MCOS - ACCOUNTABILITY

- The State Medicaid Agency's contract with MCOs delegates the health care services for Medicaid beneficiaries to the MCOs
- Due to the "capitated payments" it is difficult to know what the MCOs actually do - and do not - provide and pay for
- Because of MCOs' ability to develop and create their own network of providers and suppliers, there is risk that a provider/supplier will be excluded
- MCOs' reimbursement to providers/suppliers is set by the MCOs - not by Medicaid

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SOLE SOURCE CONTRACT

- Is a contract for a product or service that is only available through a specific vendor

OR

- A contract with identified, specified justifications to allow awarding a contract to a specific supplier

AND

- Sole source contracts preclude suppliers that meet the conditions for providing the services and supplies.

SOLE SOURCE CONTRACT

- Diminishes competition
- Promotes favoritism
- Does not secure the best services and products at the best price
- Denies beneficiaries' choice
- Increases risk of fraud, waste and abuse
- Risk of inability to provide services and products to beneficiaries (drop ship will not work during a hurricane or winter storm)

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CASE STUDY

- Centene's Medicaid Managed Care Companies are given local names such as:
  - Texas: SuperiorHealth
  - Ohio: Buckeye Community Health Plan
  - Illinois: IlliniCare
  - New Mexico: Western Sky Community Care
  - Mississippi: Magnolia Health
- In Illinois, IlliniCare cut reimbursement to DME suppliers by approximately 50%
- **********.hmenews.com/article/mco-readies-drastic-cuts-illinois

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CASE STUDY

- Centene's Texas MCO, SuperiorHealth, announced it had entered a Sole Source Contract with Medline for the exclusive rights to:
  - Four Texas Medicaid Plans, to the exclusion of other Texas DME suppliers:
    1. STAR
    2. STAR Health
    3. STAR+PLUS
    4. CHIP

CASE STUDY

- SuperiorHealth's Sole Source Contract with Medline excluded other Texas DME suppliers from providing the following products under the four Texas Medicaid Plans discussed in the preceding slide:
    - 244 HCPCS – 244 unique items; 6 pages of 10 categories:
        - Diabetic supplies
        - Tracheostomy supplies
        - Compression garments
        - Urological
        - Enteral supplies
        - Breast pumps
        - Incontinence supplies
        - Wound care supplies
        - Ostomy
        - Miscellaneous

CASE STUDY

Alliance Medical Supply – July 20, 2017

Filed a Complaint Against SuperiorHealth with Texas HHSC –

Complaint alleged that the awarding of the Sole Source Contract to Medline denied the beneficiary's right to choose a DME supplier

- Suppliers with long standing relationship with beneficiaries
- Suppliers that are conveniently located
- Suppliers that personally handle DME needs (i.e., Hurricane Harvey)
- Violation of Texas Medicaid Code – Denial of Choice
- No notice provided to beneficiary – automatically

CASE STUDY

Complaint further alleged that the Sole Source Contract gave benefits only to Medline

- Eliminated prior authorization requirement
- Authority to "pre-populate" physician order forms and send the form to the ordering physician for approval and signature

CASE STUDY

The Complaint further alleged that the Sole Source Contract

- Removed verification, compliance with coverage, and medical necessity documentation … which all other DME suppliers must provide
- Removed competition
- Increased risk of:
  - Violation of the federal anti-kickback statute – Physicians encouraged to refer to Medline vs. other suppliers
  - Fraud, Waste and Abuse – removed audit for (i) billing for services not provided, (ii) upcoding, and (iii) proof of medical necessity

CASE STUDY

Texas HHSC Medicaid Responded:

- No exclusive supplier contracts but may have "preferred provider/supplier"
- Mandated that SuperiorHealth provide a written "opt-out" for any reason … or for no reason
- SuperiorHealth must provide 30 day notice of the Medline contract to beneficiaries

CASE STUDY

- In late January 2018, Superior HealthPlan sent letters to Texas DME suppliers (i) announcing a new fee schedule and (ii) attaching an Amendment to the Participating Provider Agreement.
- According to the letter, the new rates were based on market analysis of Superior HealthPlan's network.
- The letter and Amendment pertained to items previously set out in the initial Sole Source Contract between Superior HeathPlan and Medline.
- The Amendment reduced reimbursement from 85% of Medicaid reimbursement to 60% of Medicaid reimbursement for the majority of DME suppliers … with a few suppliers receiving a reduction to 65% –

CASE STUDY

- The Texas DME suppliers were given 30 days to accept or reject the Amendment.
- The Amendment would "automatically become effective" if the supplier did not decline within the 30 days. If the supplier chose to decline, it would be required to contact Superior HealthPlan via certified mail within 30 days of receipt of the letter … at which time the Participating Provider Agreement with Superior HealthPlan would be terminated on May 1, 2018.
- Superior HealthPlan subsequently clarified that a rejection would terminate all services under the Participating Provider Agreement … not just the items listed on the Amendment.

CASE STUDY

- The Texas Association of Medical Equipment Providers ("TexMEP") responded by gathering information from Texas DME suppliers.
- A number of suppliers expressed a concern that the reduced rates would force many suppliers to drop off the Superior HealthPlan panel … resulting in Medline effectively becoming the "sole source supplier."
- In addition, a number of Texas DME suppliers stated that they were informed by their Superior HealthPlan member patients ("SHP patients") that Medline was drop shipping supplies to them with a "Welcome to Medline" letter.
- According to the Texas DME suppliers, they were informed by SHP patients that at least a portion of the drop shops were to SHP patients who (i) had opted out of Medline in 2017 and

CASE STUDY

- According to a number of Texas DME suppliers, (i) SHP patients began to call them to find out how Medline had obtained the SHP patients' names, addresses, and other information and (ii) a number of SHP patients pointed out that the Medline shipments were exactly what they had been receiving from their Texas DME suppliers.

CASE STUDY

- In coordination with TexMEP, Brown & Fortunato (i) filed a formal Complaint with Texas HHSC on behalf of BritKare (an Amarillo, TX based DME supplier) and (ii) supplemented the Complaint with Superior HealthPlan's letter, Amendment showing the reduced reimbursement, a comparison of the items covered by the previous Sole Source Contract with the items in the Amendment, and the information from Texas DME suppliers regarding the drop shipments.
- After Texas HHSC reviewed the information, the Amendment was suspended.

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STEPS THAT SUPPLIERS CAN TAKE

- File a complaint with the state Medicaid agency
- Lobby state legislators, particularly those who have jurisdiction over the state Medicaid program
- Hire a law firm to (i) assist in filing the complaint, (ii) assist with the lobbying efforts, and (iii) determine if litigation is feasible
- Hire a lobbying firm to assist with lobbying state legislators
- Hire a public relations firm to assist with circulating stories in newspapers, on television, on the radio, and in the social media.
- Enlist the help of the state DME association
- Enlist the involvement of patient advocacy groups
- Television, radio, newspaper and social media
- Remember that state Medicaid programs are funded by both the federal government and the state government. Therefore, it is worthwhile to contact U.S. legislators (Senators and Representatives). It is also worthwhile to contact CMS.

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ARGUMENTS THAT SUPPLIERS CAN MAKE

- Inadequate patient care
- Patient complaints
- Lack of patient choice
- Inadequate number and types of suppliers … and lack of geographical diversity among suppliers
- Failure to pay for services and/or "slow pay"
- Risk of fraud, waste and abuse
- Risk to Medicaid funds, specifically, the sicker the beneficiaries are (because of lack of services), then the higher the risk that they will end up in the hospital ER
- Risk to Medicaid beneficiaries – Their health will deteriorate if they do not receive adequate products/services.

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CONTRACT BETWEEN SUPPLIER AND MCO

- All contracts between suppliers and MCOs allow the MCO to amend the contract by giving advanced notice to the supplier.
- Here is typical language: "This Agreement and any Attachments may also be amended by HMO furnishing Provider with any proposed amendments. Unless Provider objects in writing to such amendment during the thirty (30) day notice, Provider shall be deemed to have accepted the amendment."

CONTRACT BETWEEN SUPPLIER AND MCO

- All contracts between suppliers and MCOs have "dispute resolution" provisions.
- For example, the contract may set forth both informal and formal resolution processes for disputes "arising with respect to the performance or interpretation of this Agreement." In our example, the informal process first requires an exhaustion of the processes set forth in the MCO's Provider Manual
- In our example, the Provider Manual establishes a provider complaint process that "allows for a provider to dispute the policies, procedures, or any aspect of the administrative function"... of the MCO.
- In our example, if the dispute remains unresolved after 60 days, either the supplier or the MCO may submit the matter to arbitration.

COMMUNICATIONS WITH COVERED PERSONS

- Let's assume that in the supplier's state, there are eight MCOs and the supplier is on the panels for all eight MCOs. Assume that ABC MCO notifies the supplier of a large rate reduction.
- The supplier may desire to terminate its contract with ABC MCO and (i) try to move the supplier's ABC MCO patients to XYZ MCO and (ii) advertise to the general Medicaid population that they should use XYZ MCO, rather than ABC MCO.
- In communicating with covered persons, the supplier needs to be mindful of the restrictions placed on the supplier.
  - For example, the Ancillary Services Provider Agreement ("Provider Agreement") between the supplier and ABC MCO may require the supplier to "obtain Payor's and HMO's approval for Covered Person communications ..."
  - The Provider Agreement might contain the following provision: "Provider shall not conduct marketing activities unless expressly approved in writing and only after all training and credentialing

COMMUNICATIONS WITH COVERED PERSONS

- In a contract between an MCO and the state Medicaid program ("State Contract"), "marketing" may be defined to mean "any written or oral communication from [MCO] or its representative that can reasonably be interpreted as intended to influence a Participant to enroll, not to enroll, or to disenroll from a health care delivery system."
- Even though the definition set out in the preceding bullet does not specifically apply to actions by suppliers, it may be construed to be applicable to the definition of "marketing" set out in the Provider Agreement.
- As such, there is a risk that a communication by a supplier notifying patients that the supplier has terminated its contract with the MCO and providing patients with a list of MCOs with which the supplier

COMMUNICATIONS WITH COVERED PERSONS

- Separate and apart from the supplier's contractual obligations, guidance regarding communications with patients will likely be set out in the Medicaid program's *Managed Care Manual for Medicaid Providers* ("Manual").
- The Manual may set out a process for suppliers to "educate" their patients about their choices between the different MCO plans.
  - For example, the Manual may state that "[I]f a Provider chooses to educate [its] patient...[the Provider and its staff] must ensure that the patient is aware of all plan choices and use materials approved by the Department for this education.'
  - It is not uncommon for the state Medicaid program to publish a flyer/template for suppliers to utilize when communicating with their patients. The template may require the supplier to identify all health plans with which it is contracted and also direct the patient to the Medicaid program's Participant Enrollment Services

COMMUNICATIONS WITH COVERED PERSONS

- The state Medicaid program may give the supplier the option to include a preferential statement regarding a certain MCO plan in the flyer/letter if the preference is a benefit to the patient, and not just a benefit to the supplier.
- If the supplier is given such an option, then it is likely that the flyer/letter must be submitted for approval by the preferred MCO and the state Medicaid program.
- The Medicaid program will likely instruct suppliers not to include any false or disparaging statements regarding MCO plans.

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COMMUNICATIONS WITH COVERED PERSONS

- The Manual may prohibit the supplier from contacting patients by telephone to (i) inform them that the supplier has terminated its agreement with ABC MCO and (ii) suggest that the patient switch out of the ABC MCO plan.
- For example, the Health Plan Outreach Guidelines in a state may prohibit "face-to-face outreach by the Health Plan directed at participants or potential enrollees, including direct or indirect door-to-door contact, telephone contact, or other cold-call activities …"
  - While the above language applies to telephone calls by the MCO, the state Medicaid program may apply the restrictions to suppliers

FACEBOOK AD

- Assume that a supplier terminates its contact with ABC MCO and desires to direct its patients to XYZ MCO. Assume that the supplier desires to run Facebook adds that inform patients of the termination and the desire by the supplier that the patients switch MCO plans.
- The supplier needs to carefully word such an ad.
  - The ad cannot be misleading. For example, if the ad says that ABC MCO is reducing patient choice, then such a statement may be misleading. ABC MCO might argue that the supplier can remain in network with ABC MCO so long as the supplier is willing to accept the lower reimbursement.
  - In addition, the supplier may be required to obtain approval of the Facebook ad by the state Medicaid program and ABC MCO.
  - The Manual may require the supplier to use materials (intended to educate patients) that have received the prior approval by the state Medicaid program.
- Lastly, it is important that the Facebook ad not be looked at as "tortious interference" with ABC MCO's business.

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FACEBOOK AD

- A properly-worded Facebook ad might say something like the following: "You have a choice in your Medicaid Managed Care plan. If you have respiratory problems, diabetes, or use oxygen, incontinence products or a wheelchair, please make sure that your provider of choice for medical equipment and supplies is in-network with the Medicaid Managed Care plan you choose."
  - By broadly stating facts not specifically identifying ABC MCO, this language should eliminate the risk of ABC MCO objecting to the ad on the grounds that it is misleading or defamatory.
  - In addition, as the ad does not specifically identify ABC MCO and is not specifically targeted to ABC MCO members, it significantly reduces the risk of a tortious interference claim.
  - Preferably, the Facebook ad will be placed by the state DME association and not the supplier. In doing so, it will be

LETTER TO PATIENTS

- Assume that DEF Supplier will terminate its contract with ABC MCO because DEF cannot accept ABC MCO's reimbursement cuts.
- A properly worded letter from DEF to its ABC MCO patients might say something like the following:
  - "The purpose of this letter is to inform you of an upcoming change in the provision of our products and services. On [date], we will no longer be contracted with ABC MCO and will not be able to continue to service your durable medical equipment or medical supply needs under the ABC MCO plan."
  - "The [name of state] Medicaid program requires most individuals with a Medicaid card to pick a health plan for their care coordination services. The health plan you pick will provide you with all of your health care needs and help coordinate your care."
  - "The health plans you may be required to pick go by the following names: (i) _____ and (ii) _____."
  - "DEF provides health care to the following population: (i) Family Health Plans; (ii) Seniors and Persons with Disabilities; and (iii) ACA Adults."
  - "DEF also contracts with the following Health Plans to provide services to our patients: (i) Health Plan 1; (ii) Health Plan 2; (iii) Health Plan 3; (iv) Health Plan 4; (v) Health Plan 5; (vi) Health Plan 6; and (vii) Health Plan 7."

STATE ANY WILLING PROVIDER LAWS

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STATE ANY WILLING PROVIDER LAWS

- "Any Willing Provider" statutes are laws that require health insurance carriers to allow health care providers to become members of the carriers' networks of providers if certain conditions are met. Such statutes prohibit insurance carriers from limiting membership within their provider networks based on geography or other characteristics, so long as a provider is willing and able to meet the conditions of network membership set by the carrier.
- Laws can be broad in scope, applying to some, most or all licensed providers in the state. Broad laws typically either spell out a list of providers covered by the provisions (e.g., physicians, pharmacists, chiropractors, speech therapists,

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STATE ANY WILLING PROVIDER LAWS

- Laws can also be limited in scope. Frequently, the limited provisions apply to only pharmacies or pharmacists. In some cases, they apply to a limited number of allied professionals such as chiropractors, optometrists, psychologists and social workers.
- As with most state regulation of insurance, "Any Willing Provider" laws generally apply to only state regulated policies, especially "fully funded" insurance, and do not apply to "self-funded" insurance plans, such as those offered by the largest employers. ERISA creates rules and standards for employers who choose to offer pensions and health benefits to employees. ERISA prevents states

STATE ANY WILLING PROVIDER LAWS

- **27 states** have "Any Willing Provider" statutes: Alabama, Arkansas, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Missouri, New Hampshire, New Jersey, North Carolina, North Dakota, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin and Wyoming.
- The requirements of these laws are summarized as follows:

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STATE ANY WILLING PROVIDER LAWS

- **Alabama –** Applies to hospitals, doctors, pharmacists, pharmacies, and any other provider of Medicaid services.
- **Arkansas –** Allows enrollees to select their health care provider. Allows patients to sue insurers or managed-care companies for violations.
- **Connecticut –** Applies to pharmacies.
- **Delaware –** Applies to pharmacies.
- **Georgia –** Applies to "every doctor of medicine, every doctor of dental surgery, every podiatrist, and every health care provider within a class approved by the health care corporation."
- **Idaho –** Applies to all health care providers.
- **Illinois –** Applies to non-institutional providers.
- **Indiana –** Applies to all providers.
- **Kentucky –** Applies to all providers within the geographic area covered by the benefit plan.

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STATE ANY WILLING PROVIDER LAWS

- **Louisiana –** Applies to all providers who wish to contract with the Louisiana State University Health Sciences Center Health Maintenance Organization.
- **Maine –** Applies to pharmacy providers.
- **Massachusetts –** Applies to pharmacies.
- **Minnesota –** Allows patients freedom of choice of providers for fertility services, family planning services not including abortion, and testing for STIs and HIV/AIDs.
- **Mississippi –** Applies to pharmacists, pharmacies, and dentists. Allows residents in long term care facilities to choose any pharmacist that meets the standards of the long-term care facility.
- **Missouri –** Applies to physicians. Allows residents in long-term

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STATE ANY WILLING PROVIDER LAWS

- **New Hampshire** – Applies to pharmacies.
- **New Jersey** – Applies to pharmacies.
- **North Carolina** – Applies to pharmacies.
- **North Dakota** – Applies to pharmacies and pharmacists.
- **South Carolina** – Applies to pharmacies and pharmacists.
- **South Dakota** – Applies to pharmacies and pharmacists. Also applies to "all health care providers who are willing, qualified and meet the conditions for participation."
- **Tennessee** – Applies to pharmacies and pharmacists.

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STATE ANY WILLING PROVIDER LAWS

- **Utah –** Applies to any health care provider licensed to treat any illness or injury within the scope of the health care provider's practice, who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider.
- **Virginia –** Applies to a broad range of providers, including pharmacies.
- **West Virginia –** Applies to any physician or behavioral health provider.
- **Wisconsin –** Applies to health care professionals, services, facilities, and organizations.
- **Wyoming –** Applies to all providers.

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EXERTING PRESSURE ON A PLAN

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EXERTING PRESSURE ON A PLAN

- There is an old legal saying: "Possession is 9/10ths of the law."
- At the end of the day, the Plan possess the DME supplier's money. And no matter how unfair or abusive the Plan may be acting, if the supplier cannot pry its money from the Plan, then the supplier will be hurting.
- In addition, the Plan has more money than the supplier and has the financial ability to "lawyer up" and litigate.
- And even if the supplier prevails somewhere "down the road," it may be broken before it finally secures its money.
- In short, the Plan has the superior bargaining

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EXERTING PRESSURE ON A PLAN

- For the above reasons, the supplier should engage in an adversarial relationship with a Plan only as a last resort. This can be referred to as "Break the Glass."
- There are a number of steps that a supplier can take in an attempt to persuade a Plan to (i) allow the supplier onto a network and (ii) play fairly with a Plan once it is in the network.

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ADMISSION ONTO A PLAN

- The first step the supplier should take is to determine if the state has an "any willing provider" statute and if it does, whether the statute includes DME suppliers.
- The supplier should also review the statutes/regulations that govern Medicare's (or Medicaid's) authority to contract with the Plan. Is the Plan given the authority to exclude providers and suppliers that are wiling to serve the Plan's covered lives in accordance with the Plan contract?

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ADMISSION ONTO A PLAN

- If the DME supplier has a good relationship with a hospital or physician group that is a lynchpin to the Plan in the supplier's community, then the supplier can ask the hospital or physician group to lobby the Plan on the supplier's behalf.
- If the DME supplier has a niche...a unique skill set...that other suppliers do not have, then the supplier can lobby the Plan to allow the supplier into the network for the limited purpose of providing the supplier's niche products and services.
- If the supplier can "get its foot in the door" in this limited capacity, then it may be easier for the supplier to later persuade the Plan to allow the supplier to provide the full array of products.

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ADMISSION ONTO A PLAN

- As much of a cliche as this may sound, under the heading of "the squeaky wheel gets the grease," if the supplier consistently "hounds" the Plan for admission into the network, then the Plan may relent.
- An argument that a supplier can make to a Plan is that the supplier has collected and "crunched" data showing how the supplier's products and services keep the supplier's patients out of the hospital.
- The supplier can represent to the Plan that the supplier will continue to collect and analyze such data on into the future so that the supplier can "prove its worth" to the Plan.

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ADMISSION ONTO A PLAN

- If the Plan is a Medicaid Managed Care Plan, then the supplier can contact its state Representative and/or Senator and ask him/her to intervene with the state Medicaid program.
- The local elected official may need to work through a legislative colleague who sits on the committee that oversees the Medicaid program.
- If the above steps are unsuccessful, then the supplier can engage in a public relations campaign.
- Assume that despite its efforts, the supplier is not admitted into the Plan's network.
- The supplier may consider entering into a subcontract arrangement with a supplier that is in the network.

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"BREAK THE GLASS" - ADVERSARIAL STEPS

- Assume that the supplier signs a contract with the Plan...but then the Plan takes steps that the supplier considers to be violative of the contract and/or that are otherwise abusive.
- Each state has an agency that oversees insurance companies that operate in the state. For purposes of these slides, we will refer to such an agency as the "Insurance Commission."
  - In Florida, the applicable department is called The Florida Department of Financial Services. In this department, there is an Office of Insurance Regulation. In addition, the Agency for Health Care Administration ("AHCA") administers the Statewide Medicaid Managed Care ("SMMC") program.
  - In Texas, insurance is regulated under the Texas Department of Insurance. Texas also utilizes the Health and Human Services Commission for some insurance complaints.
  - In Ohio, insurance is regulated by the Department of Insurance. In addition, the Ohio Department of Medicaid implements the state's Medicaid program.

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"BREAK THE GLASS" - ADVERSARIAL STEPS

- The supplier should determine the procedure for filing a complaint with the Insurance Commission against the Plan.
  - In Florida, providers that participate in a Managed Medicaid Plan must first submit their complaints to the Plan, and use the Plan's complaint/appeal process, before submitting a complaint to AHCA. A complaint can also be filed within the Florida Department of Financial Services. Remedies include fines and cease and desist orders.
  - In Texas, the provider must first follow the Plan's grievance and appeals process . . . after which a complaint can be sent to the Health and Human Service Commission.
  - In Ohio, the Superintendent of Insurance is the CEO and director of the Department of Insurance. He/she has the responsibility to ensure that the laws relating to insurance are executed and enforced. Before a provider can file a complaint with the Department of Insurance, the

"BREAK THE GLASS" - ADVERSARIAL STEPS

- The supplier can consider filing a lawsuit against the Plan. In so doing, the supplier can ask the court to issue an order allowing the supplier into the network...pending final outcome of the lawsuit.
- If a credible argument can be made that the law allows it, then the supplier can ask for actual damages and perhaps punitive damages.
- Potential grounds for such a lawsuit might include:
  - Breach of contract by the Plan.
  - Violation by the Plan of the Insurance Code.

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"BREAK THE GLASS" - ADVERSARIAL STEPS

- Potential ground for a lawsuit (cont.):
  - Violation of the state's deceptive trade practices act.
  - Violation of state laws pertaining to (i) tortious interference with business relations and (ii) unfair competition.
    - Florida has the Unfair Methods of Competition and Unfair or Deceptive Acts or Practices law.
    - The Texas Insurance Code includes a prohibition against deceptive and unfair practices. There is also a Deceptive Trade Practices Act under the Business Commerce Code that prohibits misrepresentation by insurers.

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