KANCARE

CONTRACT REVIEW CHECKLIST

UPDATED AUGUST 2018

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KANSAS HOSPITAL ASSOCIATION
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STATEMENT OF PURPOSE

The purpose of the Kansas Hospital Association KanCare Contract Review Checklist is to identify and address general issues relating to the terms of formal network provider agreements between hospitals and the managed care organizations selected by the State to operate the KanCare program. This Checklist does not constitute legal advice. If the reader has a specific question regarding the legal implications of a particular contract term, he or she should seek legal advice from qualified counsel.

This Checklist is not intended in any way to facilitate or promote conduct among the Association's membership which is, or could be viewed as, anti-competitive. Such conduct would include agreements to fix prices or discussions about prices or costs; inappropriate collective fee negotiations or exchange of price or cost information; group boycotts or threats to boycott; collective refusals to deal; agreements to limit outputs; agreements to divide the market or allocate customers among competitors; and unfair trade practices. Member hospital representatives should refrain from discussions relating to any of these prohibited activities during meetings or privately.

INTRODUCTION TO THE
KANCARE CONTRACT REVIEW CHECKLIST

Effective January 1, 2013, the State of Kansas, with limited exceptions, delegated the operation of the Medicaid/CHIP program to three managed care organizations (MCOs). The MCOs' specific duties and responsibilities are defined by written contracts with the State approved by CMS. The MCOs, in turn, contract with providers regarding the terms of their participation in the program, now known as KanCare. Pursuant to an RFP issued in 2017, the State awarded contracts (to begin January 1, 2019) to three MCOs – Sunflower State Health Plan, Inc., United Healthcare Midwest, Inc., and Aetna Better Health of Kansas, Inc.

Sunflower and United are currently KanCare MCOs. Aetna is a new contractor. Currently, Aetna's proposed provider agreement is under review by the State. Another source of information regarding the structure of the KanCare program is the State's 2017 Request for Proposal (RFP) directed to MCOs that might bid on the contract. This Checklist will reference, from time to time, the RFP's description of the intended relationship between an MCO and its network providers. The RFP can be found at https://admin.ks.gov/offices/procurement-and-contracts/kancare-award.

Keep in mind that Medicaid managed care is a very different animal from private payer managed care. Under private payer plans, the payer pays a provider a per-member fixed rate for a specific period of time during which the provider will furnish medically necessary covered services to a member.

Under KanCare, however, the State will pay an MCO a per-member fixed rate to arrange for the provision of and payment for medically necessary covered services. The MCO, in turn, will pay its network providers on a fee-for-service basis using the established Medicaid fee schedule (unless the parties agree otherwise as specified in the RFP).

Network adequacy requirements are described in Section 5.5.3 of the RFP. Geographic access standards can be found at www.kancare.ks.gov/policies-and-reports/network-adequacy (posted August 6, 2018).

The RFP requires an MCO to make three reasonable offers (at or above the Medicaid fee schedule rate) to all inpatient hospitals. If an MCO does not contract with a hospital, it must pay the non-participating provider (non-par) hospital 90 percent of the Medicaid fee schedule rate. The non-par hospital is prohibited from balance-billing the member.

An MCO must offer contracts to all critical access hospitals (as well as all rural health clinics and federally qualified health centers). An MCO must notify the State if it is unable to contract with one of these entities. MCOs must pay CAHs according to the DRG fee schedule, and must pay RHCs and FQHCs at the PPS rate in effect on the date of service for each Encounter.

A hospital should take into consideration these requirements in negotiating with an MCO. Depending on the specific circumstances, a hospital may use the network access requirements and similar RFP requirements as leverage to secure additional (or alternative) payment and/or favorable contract terms.

While negotiation of private managed care contracts centers around the *amount* to be paid to the provider, KanCare contracting likely will focus on the *manner* in which providers are paid by the MCOs. This has proven to be the case in those states that have implemented broad-scale Medicaid managed care programs similar to KanCare. In light of this, this Checklist identifies key issues relating to the payment process and includes model contract language intended to be considered when negotiating with MCOs.

In contracting with MCOs, a hospital should follow its established procedures for contract review and approval, including the following:

> First, any proposed agreements received from an MCO should be forwarded immediately upon receipt to the designated individual in the organization for review and negotiation. As necessary and appropriate, such individual should involve legal counsel.
>
> Second, the designated individual should involve all appropriate persons in the organization in reviewing the draft agreement. A hospital should not sign a contract unless and until the designated individual has confirmed the hospital has the capability and capacity to perform each of the duties specified in the document. Any vague or confusing provision should be addressed with the MCO, with the MCO's response to any such inquiry properly documented.
>
> Third, the contract should be signed by the person with the proper authority to bind the organization to the terms of the agreement (which may or may not be the designated individual referenced above). The fully executed agreement (signed by all parties, with all referenced exhibits physically attached or identified by objective, verifiable fact) should be maintained in the hospital's contract management system.

KEY CONTRACT TERMS AND CONSIDERATIONS

I. Preamble. The preamble should list the full legal name (including any d/b/a) of each party and the contract's effective date (the date on which the parties assume their respective duties under the contract, not the date on which the parties sign the contract). This section of the contract also includes recitals between the contracting parties which simply identify the parties (*e.g.*, "Hospital is a Kansas non-profit corporation that holds a license from the State of Kansas to operate a hospital in Hometown, Kansas, and participates in the Kansas Medicaid Program"), the proposed relationship of one party to the other, and the broad purposes of the contract. The statements in the preamble should be consistent with the hospital's understanding of its rights and responsibilities as well the specific provisions of the contract.

II. Definitions. Definitions of key terms may appear in a single section (or as an exhibit or appendix to the contract) or be dispersed throughout the contract. Typically, defined terms will be capitalized each time they are used in the contract to indicate the term has a specific meaning. If a hospital has any question regarding the manner in which a term is used in a draft contract, it should ask the MCO to incorporate a definition for that term in the contract. Attachment A to the RFP contains a listing of defined terms and acronyms as those terms/acronyms are used in the RFP.

How specific terms are defined in a contract is critical to determining the parties' respective rights and responsibilities in specific circumstances. Generally, the following terms should be defined in the contract:

A. *Agreement*. Refer to all relevant exhibits, attachments, schedules, and cross-referenced documents (*e.g.*, provider manuals, policies and procedures, and member manuals). If any such document may be unilaterally modifiable by the MCO at a future date, include a date in identifying that document (*e.g.*, "as in effect on January 1, 2013").

B. *Covered Services*. Identify all health care services for which the MCO will make payment to the hospital, provided certain terms and conditions are satisfied (*e.g.*, medical necessity). The RFP requires an MCO to include (at a minimum) as Covered Services those services listed in Attachment C to the RFP. If the definition in the hospital's proposed Provider Agreement makes reference to another document for a list of Covered Services, that document should be specifically identified in the contract and readily available to the hospital.

C. *Emergency Services* and *Emergency Medical Condition.* The definitions of these terms will determine whether a hospital will receive adequate payment for services furnished in its emergency departments. Thus, it is in a hospital's best interests to include definitions consistent with its obligations under EMTALA.

"Emergency medical condition" should be defined in the same manner as in the federal Emergency Medical Treatment and Labor Act and its implementing regulations. The definition in the RFP reflects the EMTALA definition.

A hospital should be wary of any provision that could be interpreted to exclude coverage for EMTALA-mandated medical screening examinations and/or limits coverage to those ED claims coded with a diagnosis that represents a disease or condition that is recognized as a medical emergency.

"*Emergency services*" includes any and all services a hospital is required to perform under the Emergency Medical Treatment and Labor Act and its implementing regulations without regard to the individual's ability to pay.

D. *Medical Necessity*. Whether a service is "medical necessity" typically drives the MCO's decision to make payment to the hospital for a specific Covered Service; and thus, the term is critically important to the parties' agreement.

The RFP requires MCOs to "disseminate the Kansas medical necessity definition, medical necessity criteria, authorization policies, procedures, and any applicable practice guidelines to all affected Providers and, upon request, to Members and potential Members."

The RFP includes the following definition of Medical Necessity:

"*Defined in K.A.R. 30-5-58 and the State will reference this citation in any discussion regarding the definition of medical necessity. In addition, [the MCO] is responsible for covering services related to the following:*

(1) The prevention, diagnosis, and treatment of health impairments.
(2) The ability to achieve age-appropriate growth and development.
(3) The ability to attain, maintain, or regain functional capacity.

The definition of medical necessity in K.A.R. 30-5-58 is attached to this to this Checklist as Exhibit A. It is extremely lengthy, with many imbedded definitions and vague variables such as "cost-effectiveness." Such ambiguity could create considerable leeway for MCOs to deny claims. This highlights the importance of the "medical necessity criteria, authorization policies, procedures, and applicable practice guidelines" (Criteria and Guidelines) that the RFP requires be disseminated to providers. If at all possible, hospitals should have the Criteria and Guidelines in hand and review, understand, and negotiate them (to the extent possible) before signing an MCO contract.

III. **<u>Non-Discrimination</u>.** An MCO may require a hospital to make an affirmative statement that the hospital will not discriminate based on race, color, creed, national origin, handicap, sex, sexual orientation, age, religion, state of health, need for health services, or status as a Medicaid recipient.

At the same time, a hospital should be protected against unfair claims that it discriminated against a member by not making all Covered Services immediately available.

Sample provision:

Service Availability. MCO acknowledges not all Covered Services are available on a 24-hour per day, 7-day per week basis (e.g., cardiac catheterization laboratory, outpatient surgery, certain diagnostic testing, etc.). Accordingly, MCO will not deny claims or otherwise penalize Hospital for services that are not made available and provided to Members on a 24-hour per day, 7-day per week basis consistent with standards of the Hospital in question as are applied to all other of Hospital's patients.

IV. Credentialing/Peer Review. Accreditation agencies generally require that the MCO take ultimate responsibility for credentialing (although the credentialing functions can be delegated if done appropriately). Credentialing/peer review procedures should be clearly stated and should include adequate appeal/due process rights prior to any termination of a provider under the plan. Such credentialing procedures should be consistent with state law related to confidentiality of peer review records and qualified immunity. The MCO should agree that confidentiality of credentialing/peer review records will be maintained to the fullest extent permitted by law. Recent Kansas legislation requires KDHE to develop uniform standards for MCOs for credentialing and re-credentialing.

V. Utilization Review. Utilization review criteria should be established. The MCO utilization review program should be attached as a schedule or reviewed in advance so that it can be determined if compliance is achievable. The utilization review procedures should include a procedure to appeal adverse UR decisions. Recent Kansas legislation requires KDHE to develop uniform standards for MCOs for retrospective utilization review of readmissions.

Medicaid MCOs in other states unilaterally have imposed a hard-line 24-hour rule for inpatient services. To avoid this, consider negotiating for a provision requiring the MCO to review inpatient admission decisions based on the information the admitting physician had at the time of the admission order (consistent with current Medicare policy).

VI. Communication/Point of Contact. A method of communication between the MCO and the hospital should be established with points of contact named by title or position.

VII. Marketing/Advertising. The contract should delineate the marketing method and control over advertising between the MCO and the hospital. Preferably, neither party should use the other's name, telephone number, address, etc., without prior written consent.

VIII. **Grievances/Dispute Resolution.** The contract should include a method for settling grievances, including methods to resolve medical necessity determinations, billing disputes, claims adjudication, payment disputes, contract compliance, and credentialing/disciplinary actions. Attachment D to the RFP details the contractual requirements for the grievance, reconsideration, appeal, and state fair hearing processes available to KanCare members and providers.

IX. **Exclusivity.** The degree of exclusivity of the contract should be stated. Hospital should be free to enter into similar provider agreements with other MCOs.

X. **Payment.**

A. Prompt Pay/Clean Claim. The RFP defines a "clean claim" as "one that can be processed without obtaining additional information from the Participating Provider of the service or from a third party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity." MCOs are required to implement the claims processing requirements set out in Attachment I to the RFP.

Under the RFP, MCOs "must pay all claims timely and accurately." Specifically, an MCO must meet the following payment requirements:

- 100 percent of all clean claims, including adjustments, must be processed and paid or processed and denied within 30 days of receipt.
- 99 percent of all non-clean claims, including adjustments, must be processed and paid or processed and denied within 60 days of receipt.
- 100 percent of all claims, including adjustments, must be processed and paid or processed and denied within 90 days of receipt.

B. Time Limits on Claim Submission. Typically, private payer contracts require the provider to submit claims within 90 to 180 days following provision of the service. However, the RFP requires MCOs to apply "a 180-day calendar filing limit for all claims for all services, and a 365-day limit for any correction or rebilling of a timely filed claim, unless the Provider agrees through their contract to an alternative timely filing time frame."

Consider negotiating for the following (if not included in the draft contract):

- Automatic exceptions and extensions to this timely filing requirement (*e.g.*, member presenting the wrong ID card, member presenting with no ID card as a self-pay patient, COB cases where the hospital filed its claim with a different payer reasonably thought to be primary payer, etc.).

- A process for the hospital to request additional time in unique circumstances (*e.g*., natural disasters).

Sample provision:

Hospital shall submit all claims within 180 days of the date of service. For inpatient admissions or observation services, the date of service shall be the date of discharge. Notwithstanding the foregoing, in the event Hospital is unable to determine that MCO is the responsible payer through no fault of Hospital (e.g., Member presenting the wrong ID card, Member presenting with no ID card as a self-pay patient) or in the event coordination of benefits is required, Hospital shall have 365 days from the date Hospital determines MCO is responsible for payment to submit a claim for Covered Services to MCO. Additionally, Hospital may request an additional 30 days in which to submit a claim for good cause shown, and such request shall not be unreasonably denied by MCO.

C. Recoupment. MCO contracts typically include provisions regarding retrospective review and recovery of overpayments. Wide MCO discretion in retrospective review can pose a substantial risk to hospitals, given that reviewers often base decisions on information regarding a member not known at the time prior authorization was sought or the service was provided. At a minimum, a hospital should have the opportunity to furnish all information and adequate time to appeal a retroactive denial to a qualified decision maker.

Considerations:

- Consider a time limit on retroactive denial of claims and recoupments.
- Consider a requirement that MCOs provide notice of the overpayment and are prohibited from reducing payments of current amounts due unless the hospital agrees to the reduction or fails to respond to notice of recoupment.

Sample provision:

No claim may be retrospectively adjusted more than 180 days after it was paid. Upon written notice with substantiating documentation, a party may request an adjustment, including an overpayment or underpayment within 180 days of the date a claim was paid. If a party determines that one or more claims requires adjustment, that party shall provide timely written notice to the other party and an explanation of each claimed adjustment. If a party disagrees with the other party's demand for an adjustment, the parties agree to first informally work together to resolve the matter. If an agreement cannot be reached informally, a party may formally initiate an appeal in accordance with Section ___, Dispute Resolution/Arbitration. If an overpayment has occurred, Hospital shall have 60

days to file an appeal or repay any overpayments. If Hospital fails to appeal or refund the amount claimed due within the 60-day period, MCO may offset the amount from future payments with an explanation of the offset and a reference to the specific claim numbers for the claims being offset. MCO shall not be permitted to offset payment against current amounts due unless Hospital specifically agrees in writing that MCO may offset or if Hospital fails to refund any overpayments within the time frame set forth above.

D. Format of Claim Submission/Remittance Advice/Payment/Denials. The RFP states that MCOs are "responsible for submitting information about services rendered and reimbursed in the HIPAA-required formats specified in the 837 Institutional Claim and Encounter Transactions, the 837 Professional Services Claim and Encounter Transactions companion guides and NCPDP standards, all of which can be found under Publications, HIPAA Companion Guides, at this website: https://www.kmap-state-ks.us/."

Considerations:

- Consider a requirement that MCOs support claim submission through both direct data entry and batch file upload.
- Consider whether, in addition to HIPAA standard transaction and code sets, other standard electronic billing and payment methods should be considered for incorporation into the contract.
- Consider a requirement that MCOs at least offer electronic billing, claims review, remit, and payment (ERA, EFT, etc.) to the contracting hospitals.

Sample provision:

MCO shall permit Hospital to submit claims and related information through direct data entry and batch file upload. MCO shall offer Hospital the opportunity to engage in standard electronic transactions for claim submission, remittance advice, and/or payment. To the fullest extent applicable, MCO and Hospital shall comply with the HIPAA standard transactions as referenced in 42 C.F.R. 162.923.

E. Coordination of Benefits ("COB"). Provisions should specify:

- Which party will make COB determinations;
- How COB will alter deadlines for claim submission and/or payment; and
- That COB is paid at the higher allowed amount of two payers.

F. Direct Patient Billing on co-payments, deductibles, and non-covered services should be allowed.

G. Payment Conditions. To avoid delays in payment through no fault of the hospitals, MCOs should be required to pay hospitals regardless of the status of payments from the State to the MCO.

Sample provision:

MCO's obligation to make full payment shall not be excused by the State's failure to make any payment due and owing to MCO, except in the event MCO is wholly without fault with respect to such delay or non-payment by the State.

XI. Service Coordination. The RFP is replete with service coordination requirements for the MCO (*e.g.*, case management, disease management, transition management, etc.). The provider contract should specify that these are the MCO's obligation. If the MCO wants the hospital to provide some or all of these services, then the contract should include payment – over and above the fee schedule amount – to the hospital for the service coordination services.

XII. Confidentiality.

A. Generally. Confidential information (including patient records, Utilization Management ("UM") statistics, financial information, and peer review information) should be protected by a provision which requires confidentiality and prohibits disclosure or use except as otherwise provided in the contract or as required by law. Confidentiality provisions should survive termination of the agreement.

B. Proprietary Information. The contract should require the MCO to:

- Maintain such information in confidence.
- Not divulge to third parties without the hospital's consent.
- Take appropriate steps to avoid disclosure to unauthorized personnel or representatives of the MCO.
- Return all copies to the hospital upon request or termination of the agreement.

C. Medical Records. The contract should state:

- The hospital owns the record.

- Protected Health Information ("PHI") will be managed pursuant to HIPAA and state law requirements. The MCO should indemnify and hold the hospital harmless from any claim by a member for breach of confidentiality resulting from the hospital's release of information to the MCO.

- The MCO may access records upon reasonable notice during normal business hours and without causing undue disruption.

- Any copies will be made at the MCO's expense.

D. UM Statistics and Peer Review Information.

- The MCO should agree not to release, publish, or distribute to third parties audits, evaluations, reports, or other information derived from the hospital's records without the hospital's written consent.

- The MCO should agree that it has no access to records, proceedings, etc., of medical review or peer review committees.

- The parties should agree that all QA and UR functions constitute peer review and are subject to all confidentiality and immunity afforded by state and federal law.

XIII. Insurance. The contract should specify the levels and types of insurance required of both parties (*e.g.*, malpractice and general liability) and require proof of insurance. An MCO that is conducting utilization review runs the risk of being sued for malpractice and should have malpractice insurance so that the hospital is not the only "deep pocket" in the event of litigation. The MCO's managed care insurance coverage should specifically include denial of benefits coverage and should not exclude antitrust liability coverage. Coverage limits of at least $10M are not atypical.

XIV. Indemnification. Consider inclusion of the following language as an alternative to a standard indemnification provision. This language creates no affirmative duty for either party to indemnify or hold the other party harmless. Instead, it merely memorializes each party's acknowledgment of the other's lack of liability. This language likely would not be binding upon a third party seeking to hold one or both of the parties liable.

Sample provision:

MCO agrees that Hospital shall not be responsible for claims, expenses, damages, or liability for personal injury or damage to property, real or personal, directly or indirectly, or indirectly arising from the negligent or wrongful act of the MCO, its officers, employees, agents, and volunteers.

Hospital agrees that the MCO shall not be responsible for claims, expenses, damages, or liability for personal injury or damage to property, real or personal, directly or indirectly arising from the negligent or wrongful act of Hospital, its officers, employees, agents, and volunteers.

If the MCO insists on a standard indemnification provision, it should be mutual (or reciprocal) between the parties.

Sample provision:

Within the limits of their respective policies of professional and general liability insurance, and to the extent not otherwise prohibited by applicable law, each of the parties hereto shall at all times indemnify and hold the other party harmless against all actions, claims, demands, costs, damages, and expenses of every kind which may be brought or made, arising from the negligence of the indemnifying party, its agents, employees, and invitees.

In addition, any indemnification should be limited, to the extent possible, as follows:

A. Attempt to limit indemnity to that portion of any liability, damage, etc., which was caused solely, directly, and independently of all other causes, by the hospital's negligence, willful misconduct, criminal conduct, or fraud.

B. Alternatively, the hospital might agree to indemnify for its negligent actions except to the extent it is determined by a court of competent jurisdiction that liability was caused by the negligence or willful misconduct of the MCO or the MCO' s directors, officers, employees, or agents.

C. Another approach would be to put a cap on cumulative liability by limiting it to the amount of reimbursement paid by the MCO (or the relevant payer) to the hospital for a specified period of time preceding the date on which the claim arose.

D. Another way to limit the potential liability is with a provision that states that (i) the indemnification only applies in the event, and to the extent that, the hospital maintains applicable liability insurance coverage, and (ii) the indemnification only applies to matters which are not covered by any other insurance maintained by the MCO.

E. The indemnity provision could specifically exclude from the indemnity any lost profits, exemplary, punitive, special, incidental, or consequential damages suffered or incurred by the MCO under any theory of recovery.

F. Another approach might be to narrow the time frame within which a claim for indemnification must be made to the earlier of (i) one year after the MCO

becomes aware of the event for which indemnification is claimed, or (ii) one year after the termination or expiration of the Agreement.

XV. **Independent Contractor Relationship.** A provision should be included attesting that each party is an independent contractor and that neither party nor their employees/officers are agents of the other. Although such a provision may more often benefit the MCO, it may also benefit the hospital in some circumstances. The MCO will likely want such a provision to specify that the hospital's network physicians (if any) shall be responsible for the quality and utilization of covered services provided and that nothing in the relationship or the agreement shall restrict or limit the physicians' medical judgment. The MCO might be able to rely on such language in an attempt to defend itself from liability arising out of improper or insufficient care provided to a member.

Similarly, it is in the hospital's interest to have such language in the agreement should liability arise out of an improper utilization management decision by the MCO. In such a situation, the hospital would want it to be clear that it is not an agent of the MCO. Thus, any such provision should be *mutual* in its applicability.

Sample provision:

This Agreement creates an independent contractor relationship between MCO and Hospital, and this Agreement shall not constitute the formation of a partnership, joint venture, employment, or master-servant relationship between Hospital and MCO.

The above sample language should be sufficient to express the nature of the relationship. To the extent possible, the hospital should try to avoid additional language intended to insulate the MCO from liability for its utilization decisions or other conduct.

XVI. **Term and Termination.** The term of the agreement should be clearly established and the method of termination established, as well as the parties' rights and responsibilities following termination.

A. "With Cause" Termination. Often, "with cause" provisions in a managed care contract favor the MCO and provide more "with cause" reasons for the MCO to terminate than for the provider to terminate. Hospitals should negotiate equal rights to terminate for reasons similar to those which may be asserted by the MCO. For example, if the MCO can terminate based on the hospital's insolvency, bankruptcy, failure to maintain licenses or accreditation, failure to maintain liability coverage and reserves, and other such obligations, the hospital should have the right to terminate for those reasons as well.

Sample provision:

This Agreement will terminate upon the occurrence of any of the following events: (a) either party notifies the other of a material breach of a warranty,

covenant, or obligation, provided that the allegedly breaching party shall have 30 days after written notice of such breach to cure the breach; (b) automatically and without notice upon the cancellation of the Hospital's general or professional liability insurance to be maintained in accordance with Section ___; (c) automatically and without notice upon the cancellation of the MCO's professional liability or errors and omissions insurance to be maintained in accordance with Section ___; (d) automatically and without notice upon either party's suspension by a state or the federal government from participation in the Medicare or Medicaid programs; (e) immediately upon written notice from the MCO if the MCO determines in its reasonable judgment that the Hospital's continued participation may jeopardize the health or safety of Members; (f) subject to continuation of care requirements in Section ____, automatically and without notice if either party becomes insolvent, or is adjudicated as bankrupt or its business comes into possession or control, even temporarily, of any trustee in bankruptcy, or a receiver is appointed for it, or it makes a general assignment for the benefit of creditors (in those instances no interest in this Agreement will be deemed an asset or liability of either party, nor will any interest in this Agreement pass by the operation of law without the consent of the other party); or (g) subject to continuation of care requirements in Section ____, immediately upon written notice by either party that the other has made any untrue statements of material fact or any intentional misrepresentation of any fact, whether or not material. [Articulate any additional scenarios for "with cause" termination as agreed by the parties.]

B. "Without Cause" Termination. MCOs will undoubtedly want the right to terminate any provider agreement without cause. However, historically, provisions permitting the MCO to terminate without cause have resulted in turmoil in other states. In Kentucky for example, a Medicaid managed care MCO gave notice to nine hospitals that the MCO was terminating contracts without cause – only to renegotiate with the same providers at lower rates or on other unfavorable terms.

Given the experiences in other states, there is a strong argument that MCOs under KanCare should not have a without cause termination right. If MCOs object to the lack of without cause termination, a hospital should challenge the MCO to articulate scenarios in which the MCO might want to exercise a without cause termination; then the parties can consider whether to include such a scenario as one reason for "with cause" termination.

C. Notice Period and Payment Following Termination. Although MCOs might be justified in requiring relatively short termination provisions for certain reasons (*e.g.*, loss of license, Medicare or Medicaid certification, or insurance coverage), if the contract allows for termination without cause or for cause unrelated to ability to deliver care (*e.g.*, change in reimbursement), a hospital should

negotiate for a sufficiently long notice period to allow for transition of care. A hospital should also assure that it will be paid for care during the notice period and afterwards until care is successfully transitioned.

Although the RFP does not address length of notice for termination, managed care laws in other contexts provide some guidance. For example, federal law governing Medicare Advantage plans requires the provider or the plan to provide at least sixty (60) days' written notice to each other before terminating a contract without cause. *See* 42 C.F.R. § 422.202 (d)(4). Federal law also requires the MCO to make a good faith effort to provide at least 30 days' written notice before terminating a contracted provider for cause. See 42 C.F.R. § 422.111 (e).

Kansas law requires HMOs to provide for continuation of care for up to 90 days by a provider who is terminated from a network if continuation of care is medically necessary and prudent and the enrollee has "special circumstances" such as a disability, a life-threatening illness, or is in the third trimester of pregnancy. The HMO must pay the provider at the previously contracted rate. K.S.A. 40-3230.

Sample provision:

If the Agreement is terminated, at the end of the term or otherwise, Hospital shall provide continuing Covered Services to any Member then receiving treatment from Hospital until the earliest of: (1) the expiration of a 90-day phase-out period (the "Phase-Out Period") commencing at the termination of the Agreement; or (2) the effective date of discharge of such Member or transfer by MCO of such Member to another facility or to another Hospital. If Member cannot be transferred to another facility or Hospital before the expiration of the Phase-Out Period without having a potential negative effect on Member's condition, then Hospital shall continue to provide Covered Services to Member until discharge or provision for safe transfer is made. MCO shall continue to compensate Hospital for Covered Services at the rates specified in Section __ until Member's discharge or transfer from Hospital's care.

XVII. <u>Pre-Authorization and Eligibility Certification</u>.

A. <u>Eligibility</u>. There should be a clear and reliable method for ascertaining eligibility. For example, a hospital might be entitled to rely on the periodic listing of members provided by the MCO or might be required (except in the case of an emergency) to call the MCO every time an enrollee comes to the office for treatment. If such separate telephone verification is required, the agreement should specify the number to call and should guarantee an immediate response. Finally, if the hospital cannot reach the MCO through the prescribed procedure, the hospital should be entitled to rely on the member's enrollment card and/or the MCO's enrollment listing.

B. Pre-Authorizations. The previous RFP requires an MCO to "[o]perate and maintain a fully-functional Prior Authorization (PA) system to support both automated and manual PA determinations and responses" with specified capabilities. Those capabilities include "[c]ommunicating the decision clearly and quickly to the healthcare provider." The current RFP does not so specify, but is nevertheless replete with references to authorization, pre-authorization, and prior authorization. It also requires MCOs to have a prior authorization capability through the MCO's website by July 1, 2019. The RFP prohibits pre-authorization requirements for emergency services or "treatment for Behavioral Health crises."

The contract should incorporate specific and demanding time frames in which the MCO must respond to a request and specify the consequences of the MCO's failure to meet those requirements (*e.g.*, care is deemed authorized)

The hospital should have the right to elect to submit requests and/or receive PA determinations in a secure electronic format consistent with HIPAA requirements.

The duty of an MCO to pay a claim for services for which the provider obtained PA should be well defined. This includes identification of those circumstances in which the MCO may use subsequently available information to overturn or adjust its initial authorization. Also, an MCO should be prohibited from denying a claim for which it previously provided a PA if the provider was not at fault with respect to such PA determination.

XVIII. Patient Volume Management. MCOs typically include in their contract provisions requiring the provider to furnish all Covered Services that the provider is licensed to provide. Such provision is intended to prevent a provider from discriminating with regard to the types of services to be furnished. MCOs also include provisions prohibiting discrimination against members based on specified criteria, including the nature of their coverage.

Taken together, these provisions require a hospital to furnish to members all services the hospital otherwise makes available, thus preventing a hospital from refusing to admit or treat a member due to the member's medical needs or the fees the hospital will receive under the contract. Given general demographic and physician shortage trends, contracting hospitals may become "overloaded" with MCO patient volume.

Hospitals wanting to protect against significant adverse changes to their payer mix may seek contractual rights to "close" its facility to, and to refuse to accept or treat, new members (other than emergency services). Alternatively, a hospital could seek closure rights to "conversion" members who previously were seen or treated by the hospital,

but have since had a change in coverage (*e.g.*, are now covered by a different plan or payer).

Sample provision:

Right to Close Acceptance of New Members. Nothing in this Agreement shall prevent Hospital from notifying MCO, upon 30 days' written notice, that Hospital is closing its services to new Members and/or to Conversion Members. The notice shall set forth the date of the Hospital's practice closure and provide any anticipated date of when the Hospital may again open up services for new Members and/or Conversion Members. For purpose of this Agreement, new Members shall be defined to mean a Member of a plan whom Hospital has not previously treated and whom has not been seen by Hospital. A Conversion Member is defined to mean an individual who may have been previously seen or treated by Hospital, and who subsequently became a Covered Member under the MCO, but who did not have MCO's coverage at the time the Hospital closed its services to any new Members. Hospital agrees to provide MCO with at least five (5) business days' written notice of the date of its services opening for new Members to make best efforts to accept new Members and cover new Members as soon as practicable.

XIX. Quality Reporting/Pay for Performance.

To the extent the hospital's continued participation and/or full payment (including bonuses or value-based purchasing payments) depends on quality reporting or scores on performance standards, those requirements should be spelled out in specific detail in the contract. These include the frequency and manner of reporting, specification on performance standards, responsibility for cost of compiling and submitting such data, and effect of non-compliance and remedial measures.

XX. Miscellaneous. Miscellaneous provisions include the following:

A. Notices. Notice provision that identifies the name and address of the parties and method by which notice is to be sent.

B. Severability. A severability provision is usually included so that the contract does not terminate if any particular provision is deemed illegal or unenforceable.

Sample provision:

Should one or more of the provisions contained in this Agreement for any reason be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provision of this Agreement, but this Agreement shall be reformed to eliminate such invalid, illegal, or unenforceable provision in a manner which most closely approximates the intent of the parties with respect thereto.

C. Representations and Warranties. Typically, an MCO will require a hospital to represent and warrant, among other things, authority to enter into the agreement, eligibility for participation in federal health care programs, and the absence of any type of fraud and abuse investigation.

D. Assignment. Generally, the contract should not be assignable by either party without prior written consent of the other.

Often, an MCO will propose assignment provisions that prohibit the hospital from assigning, but allow for assignment by the MCO without the hospital's consent. Sometimes the MCO's right to assign the agreement will be "limited" to assignment to "affiliates," "subsidiaries," "related entities," or in connection with a merger or acquisition of the MCO or its parent corporation. Many of these "limited" rights of assignment actually allow the MCO to assign the agreement to a potentially broad range of entities and give the hospital very limited comfort or control as to who may end up as the other contracting party. For example, there is often no way to know in advance whether the MCO will merge with or be acquired by another entity. Similarly, unless the term "affiliates" is defined in the agreement, that term could be construed to include entities related in any number of ways to the MCO. Generally, permitting assignment to a subsidiary represents somewhat less risk as a subsidiary is presumably an entity controlled by the MCO with which the hospital originally agreed to contract.

Otherwise, however, assignment by the MCO to another entity could result in significant changes in the contract relationship. For example, a merger or acquisition might alter the fundamental concepts upon which the provider relied in its initial decision to contract with the MCO (*e.g.*, financial, solvency, accreditation, demographics of enrollees). An assignment of the agreement could dramatically change the size and/or composition of the member pool to be served. Acquisition by another MCO could result in different policies and procedures for claims processing, UM, grievance procedures, credentialing, etc.

The magnitude and impact of these potential changes will depend in part upon the terms of the agreement that the hospital has negotiated with the MCO. For example, if the agreement places parameters around the number and composition of members to be served by the hospital, the assignee should have to abide by those parameters as well. Similarly, to the extent that the contract limits the MCO's ability to unilaterally change policies and procedures, the hospital will be at less risk of dramatic change in the event of assignment.

It should also be noted that restrictions on the hospital's ability to assign may also adversely impact the hospital. Such restrictions may limit the hospital's ability to sell or restructure its operations.

In short, the MCO's ability to assign the contract without the hospital's consent should be limited (or at least carefully defined) to the extent possible. If the MCO insists on a broad assignment provision, the hospital should carefully scrutinize the other key provisions of the agreement to assure that it is protected (or at least has the opportunity to terminate quickly) in the event of an objectionable assignment.

Sample provision:

Neither party may assign or transfer any of its rights or obligations under this Agreement without the prior written consent of the other.

E. Amendments. Ideally, amendments to the agreement (and any exhibits, manuals, policies, procedures – including, especially, fee schedules or reimbursement provisions; UR policies and procedures; credentialing policies and procedures; member grievance procedures, etc., referenced or relied upon in the agreement) should require the written consent of both parties (but not the consent of the MCO's members). If the MCO will not agree to requiring mutual consent for amendment, alternatives could be considered.

However, hospitals should not agree to a unilateral amendment provision in the contract. MCOs often push for unilateral amendment provisions that allow the MCO to modify the contract, including rates, with or without notice. MCOs also sometimes achieve such unilateral ability to amend by requiring the hospital to comply with policies and procedures, then allowing unilateral amendment of such policies and procedures. Hospitals should seek some protection from unilateral amendments particularly in the areas of processing claims and covered services. Hospitals also should limit unilateral amendments to the MCO's policies that may be referenced by the contract.

Alternatives to consider:

- Consider prohibiting unilateral amendment of the agreement by the MCO for which a hospital's sole recourse is termination of the agreement.
- Consider prohibiting unilateral MCO amendment to policies referenced in the contract.
- Consider unilateral amendment by MCO unless the hospital objects (with adequate time to respond), in which case agreement continues as is.
- Avoid: Unilateral amendment by MCO deemed accepted by the hospital if money accepted or if no objection within a short time frame.

Sample provision:

This Agreement, including any and all exhibits, attachments, and appendices hereto, can be modified or amended only by a written document, expressly referencing this Agreement and the parties' mutual intent to amend it, and executed by duly authorized representatives of both MCO and Hospital.

Hospital shall comply with applicable written policies and procedures to the extent such policies and procedures are not inconsistent with the express terms of this Agreement and to the extent that MCO has made such policies and procedures available to Hospital for review at least thirty (30) days prior to the effective date of this Agreement.

MCO shall give Hospital at least sixty (60) business days' prior written notice of any proposed addition and/or deletion and/or amendment of MCO's policies and procedures (collectively, a "Modification"). Unless Hospital consents to the proposed Modification in writing within sixty (60) business days after receipt of such notice, Hospital shall not be bound by the proposed Modification.

F. Governing Law. Kansas law governs the MCOs' contracts with the State; so, presumably, Kansas law should govern the provider agreements as well. Choice of law rules are quite complicated and vary depending upon the type of claim and from state to state. However, generally courts will honor the parties' agreement that a particular state's law will govern the interpretation and enforcement of a contract, unless that state has no connection to the parties or their relationship. Typically, managed care agreements designate the law of the state where the physician services (or at least most of such services) will be provided.

G. Arbitration. Usually, arbitration provides for a faster, less expensive resolution of claims than does litigation. Thus, arbitration clauses should be established to resolve conflicts between the parties. However, it is important to check with your professional liability insurance carrier to assure that any arbitration provision does not conflict with or limit coverage.

Sample provision:

MCO and Hospital agree to meet and confer in good faith to resolve any problems or disputes that may arise under this Agreement. If Hospital is not satisfied with such resolution, to the extent permitted by law, the matter in controversy shall be submitted to a single arbitrator selected pursuant to the rules and procedures established by the American Health Lawyers Association Dispute Resolution Services ("AHLA") or the American Arbitration Association ("AAA") within sixty (60) days of the last attempted resolution. If the matter is submitted to arbitration, it shall be conducted in accordance with the commercial

arbitration rules of the AHLA (or AAA) and shall be held in [city or county], Kansas. Both parties shall be bound by the decision of the arbitrator as final determination of the matter in dispute. Each party shall assume its own costs, but shall share equally the cost of the arbitrator. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction.

H. Third-Party Beneficiaries. The contract should state that, except as expressly stated therein, there shall be no third-party beneficiaries to the contract. The danger here is that members may be deemed third-party beneficiaries of the contract and, thereby, entitled to enforce (and receive damages for breach of) the contract between the hospital and the MCO.

Sample provision:

Nothing in this Agreement, express or implied, is intended or shall be construed to confer upon any person or entity other than the parties hereto and their respective successors or assigns, any remedy or claim under or by reason of this Agreement or any term, covenant, or condition hereof, as third-party beneficiaries or otherwise, and all of the terms, covenants, and conditions hereof shall be for the sole and exclusive benefit of the parties hereto and their successors and assigns.

I. Survival. Certain provisions, to be effective, may require performance or forbearance by a party after termination of the Agreement. Arguably, however, the parties are not bound by the Agreement after termination unless they agree to be so bound – that is, agree that certain provisions will "survive" termination. Examples of provisions that might be designated as surviving the term of the agreement include: confidentiality of information and records; access to data/records (up to a given number of years after termination); requirements for professional liability insurance and tail coverage; restrictions on competition; and member hold-harmless provisions.

Sample provisions:

[Found in each section that is intended to survive termination.] *The terms of this section shall survive any termination of this Agreement*

[General survival provision.] *The covenants contained in Sections ___, ____, and ___ shall survive any termination or expiration of this Agreement.*

Exhibit A
K.A.R. 30-5-58
Medical Necessity

(ooo) (1) "Medical necessity" means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:
(A) "Authority." The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.
(B) "Purpose." The health intervention has the purpose of treating a medical condition.
(C) "Scope." The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
(D) "Evidence." The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph (ooo)(3). For existing interventions, effectiveness shall be determined as provided in paragraph (ooo)(4).
(E) "Value." The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this regulation's definition of medical necessity. Interventions that do not meet this regulation's definition of medical necessity may be covered at the choice of the secretary or the secretary's designee. An intervention shall be considered cost effective if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.
(2) The following definitions shall apply to these terms only as they are used in this subsection (ooo);
(A) "Effective" means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
(B) "Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this regulation's definition of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.
(C) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.
(D) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.
(E) "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.
(F) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between

the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

(G) "Secretary's designee" means a person or persons designated by the secretary to assist in the medical necessity decision-making process.

(H) "Treat" means to prevent, diagnose, detect, or palliate a medical condition.

(I) "Treating physician" means a physician who has personally evaluated the patient.

(3) Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described below in paragraph (ooo)(4).

(4) The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet this regulation's definition of medical necessity in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.

(ppp) "Medical necessity in psychiatric situations" means that there is medical documentation that indicates either of the following:

(1) The person could be harmful to himself or herself or others if not under psychiatric treatment; or

(2) the person is disoriented in time, place, or person.