

# NEGOTIATING MANAGED CARE CONTRACTS

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## NEGOTIATING MANAGED CARE CONTRACTS

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This White Paper addresses (i) steps a DME supplier should take preparatory to executing a managed care contract, (ii) key provisions in a managed care contract, (iii) responsive steps that a DME supplier can take when a managed care panel is closed, and (iv) legal pitfalls that arise when a group of DME suppliers desire to negotiate with one voice.

### Summary and Overview

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 40% 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. For purposes of this White Paper, Medicare Advantage Plans and Medicaid Managed Care Plans will sometime be referred to as “Plan.”

Here is how a Medicare Advantage Plan works:

- An insurance company will create (and own) a subsidiary corporation (or LLC) that will sponsor the “Plan.” The Plan will sign a contract with CMS.
- The contract will say that the Plan will be responsible for those Medicare patients who sign up with the Plan.
- The Plan will market to Medicare beneficiaries with the goal of persuading them to “sign up” with the Plan...as opposed to staying with Medicare FFS or signing up with a competing Medicare Advantage Plan.
- The Plan will create a “network” of health care providers: hospitals, physicians, labs, DME suppliers, home health agencies, etc. A DME supplier will join the network by signing a contract with the Plan.
- When a Medicare patient sees a Plan provider, 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 CMS to be more than what the Plan pays providers and suppliers ... with the Plan “pocketing the spread.”

A Medicaid Managed Care Plan works essentially the same way:

- Less populated states may have only a couple of Medicaid Managed Care Plans.
- More populous states will have a number of Plans that compete with each other.

## **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., 1/1/22 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 difference back to 12/31/20.
- 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 notice to the supplier.
- 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.

## **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 . . . its bargaining position is.

The supplier should 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. The supplier should 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.

Prepare a list of questions to ask the Plan regarding the contract including:

- The amount of time the current contract form has been used;
- Whether or not the Plan knows of other DME suppliers that would be willing to discuss the terms of the contract;
- 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 negotiations with the Plan.

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.” 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.

## **Key Contract Provisions**

### *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.

### *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.

### *Covered Services*

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

### *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” as “any person with whom [BCBS] has entered into an agreement to provide coverage.” The contract defines “Subscriber Contract” as 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.”

### *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.

### *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.

### *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. 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 agreement in writing; otherwise, the parties will assume that the amendment has been accepted by the Provider.”

### *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.

### *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. 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. 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 or federal regulatory or accreditation requirement or to address only minor administrative or operational clarifications, as reasonably determined by Blue Cross with which case Blue Cross shall provide as much advance notice as is reasonably practical."

### *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. 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..."

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. If it is not possible to have set-off provisions removed, then the next best option is to build limitations and protections into set-off provisions.

### *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.

### *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. 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. An example of an Evergreen Clause is found in a BCBS: “[T]his Agreement shall...automatically renew for each subsequent renewal term....”

### *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.

### *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.

### *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. 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.

### *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.

### *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.

### *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.

### *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 should 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.

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. An example of a "clean claim" provision can be found in an Amerigroup contract that 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."

## *Marketing*

The supplier should request the right to review all marketing materials referring to the supplier before they are used by the Plan. 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 applicable State Contract ...”

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 this definition 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 marketing activity as it may influence the recipient to enroll with a particular Plan.

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 to learn more about Plan choice. 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. 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.

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 ads 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. 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. 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. 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 (vii) Health Plan 7.”

*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.

### *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.

### *Reimbursement*

An 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 products and services provided.

### *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.

### *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 continuity of care practices."

### *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.

### *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.” As another example, an Amerigroup contract states: “Unless otherwise approved by Amerigroup in writing, Provider shall not use any subcontracted provider to furnish Covered Services to Covered Persons.”

### *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.”

### *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.”

### *Home Set-Ups*

The DME supplier needs to determine if 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 provide training to the Subscriber and his or her family.”

### *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.”

### *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.”

### **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 possesses 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 broke before it finally secures its money. In short, the Plan has the superior bargaining position. 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.

#### *Admission onto a Plan*

It is not uncommon for a Plan to say to a DME supplier: “We have enough DME suppliers. Our network is closed.” 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 willing to serve the Plan’s covered lives in accordance with the Plan contract?

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, it may be easier for the supplier to later persuade the Plan to allow the supplier to provide the full array of products.

As much of a cliché 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, 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.

If the Plan is a Medicaid Managed Care Plan, 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, the supplier can engage in a public relations campaign.

### *“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 this article, I 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.

The supplier should determine the procedure for filing a complaint against the Plan with the Insurance Commission. 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 supplier 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 supplier can file a complaint with the Department of Insurance, the supplier must first undertake the grievance/appeals process under the Plan. 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, 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.
- Violation of the state’s deceptive trade practices act and violation of state laws pertaining to (i) tortious interference with business relations and (ii) unfair competition. For example:
  - 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.
- In Ohio, there is the Unfair and Deceptive Acts or Practices law in the Business of Insurance Act.

### **Negotiating with Plans: Avoid Antitrust Pitfalls**

It is human nature for a group of DME suppliers to want to approach the Plan and say: “Either pay us \$ \_\_\_ or none of us will accept the reimbursement cuts.” This approach will violate federal and state antitrust laws. The basic federal antitrust statutes are Sections 1 and 2 of the Sherman Act, Section 7 of the Clayton Act, Section 5 of the Federal Trade Commission Act, and the Robinson-Patman Act. Additionally, states have their own antitrust laws. Section 1 of the Sherman Act prohibits agreements that unreasonably restrain competition. Reasonableness of a restraint depends on (i) the degree of the adverse effect on competition and (ii) the degree of any procompetitive effects from the restraint.

Price fixing is an agreement among competitors to raise, fix, or otherwise maintain the price at which their goods or services are sold. If a group of DME suppliers and a Plan sit down to discuss the reimbursement paid by the Plan, the following talking points should be followed: (i) while the meeting participants can share their positions, and exchange information, the purpose of the exchange is not to reach an agreement – but rather – to exchange ideas; (ii) the participants may talk about parameters, tolerances, and win-win situations for both sides; and (iii) the suppliers might share some historical figures to outline industry practices that have benefited patients, suppliers, and the Plan in the past.

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