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Preparing for Managed Care: Payor Negotiations, Contracting Issues, Benefits of Independent Provider Associations and Useful Contracting Approaches/Structures

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Managed Care Contracting - MLTC

- Objective for today –
 - To identify, discuss, and present issues and strategies facing LTC providers in a Managed Care Reform environment
- My further objective today is to take a “deeper dive” into strategic positioning for providers related to contracting with Managed Care organizations – specifically, contracting issues and entity structures (e.g., IPAs, Regional Provider Networks, and Management Service Organizations).

Method to Achieve My Objectives

- Providing you with a Top 10 List of Managed Care facts you should know and communicate to Management and Board at your organization.
- The transition to Medicaid Managed Care for the vulnerable LTC population will affect each and every employee of your organization, either directly or indirectly.
- As you know, implementation of Managed Care principles is ongoing with enrollments focused on Care Coordination / Management of the high cost / most involved LTC population.

Top 10 Things You Need To Know

1. Be aware and knowledgeable regarding the role and responsibilities of various structures and service delivery models.

- MCO = Managed Care Organization – the primary fiscal intermediary between you, the provider, and the State of New York funding sources
- MSO = Management Service Organization
- MLTC = Managed Long-Term Care Plan / MCO
- PACE Program – Program for All-Inclusive Care to the Elderly
- IPA = Independent Provider Association / Contracting Organization
- Health Homes – Care Coordination / Management on a regional basis with integration of provider networks
- BHO = Behavioral Health Organization / Utilization Management focus (e.g., Beacon, Magellan, etc.)
- HARP = Health and Recovery Program (i.e., defined set of services available from an MCO)
- DISCO = Developmental Disability Individual Service Care Organization
- ACO = Accountable Care Organization – a product of the Affordable Care Act (Obamacare)
- ACN = Accountable Care Network – provider networks created by ACOs for purposes of contracting with the Federal Government based on “population health” principles
- Insurance Companies – Fidelis, Excellus, ILS/Humana, ElderPlan, Universal American, Blue Cross of Western New York, MVP, AmeriHealth, Emblem Health, United Health Care, etc.
- & More!

Top 10 Things You Need To Know

➤ Be aware and knowledgeable regarding the key definitions, as follows.

- Fiscal Intermediary - The structure of virtually all Managed Care plans involved the development of a fiscal intermediary. A fiscal intermediary can take a variety of forms and structures, as follows:
 - In the early days of traditional Managed Care for an employed population, the insurance company acts as the fiscal intermediary between your employer and you as the individual or family insured and enrolled in a Managed Care plan.
 - This is also true in Medicare advantage and traditional Medicaid Managed Care (excluding vulnerable populations) where the State or Federal Government has contracted with a variety of insurance companies to create, enroll, and manage various Medicare and Medicaid populations.
 - In Medicaid Managed Care for vulnerable populations, there can be multiple fiscal intermediaries (e.g., IPAs, partnerships between insurance companies and providers, Health Homes, etc.).
 - Vulnerable populations like Behavioral Health and the Developmentally Disabled may require “carve out” fiscal intermediaries that are responsible for managing the cost and service quality related to specific types of services required by the vulnerable population.
 - For example, Managed Long-Term Care Plans can be offered by providers (e.g., Visiting Nurse Association) as well as by insurance companies (e.g., Fidelis).

Top 10 Things You Need To Know

➤ Be aware and knowledgeable regarding the key definitions, as follows.

- Managed Care Organization (MCO) = An organization that combines the functions of health insurance, delivery of care, and administration.
 - MCOs are and will represent the primary fiscal intermediary between you, the provider, and the State of New York traditional funding source (i.e., DOH)
- Management Service Organization (MSO) = An organization formed by multiple providers to share and combine administrative functions for purposes of achieving operating / cost efficiencies
 - Examples of shared services:

Human Resources

Fundraising and Development

Information Technology

Managed Care Provider Contracting

Finance

Facilities/Occupancy/Maintenance

Compliance/QA

Access to Capital Financing/Credit Facilities

Transportation

Strategic Planning

Marketing, Public Relations & Communications

Administrative Functions Supporting Provider Network (e.g., IPAs)

Top 10 Things You Need To Know

➤ Be aware and knowledgeable regarding the key definitions, as follows.

- Independent Provider Association (IPA) = an individual group of physicians and / or other healthcare providers that are under contract to provide services to members / enrollees of different MCOs, as well as other insurance plans, incorporating a fixed fee per enrollee (capitation) or based on a Pay-For-Performance model (P4P) (partial capitation), service carve-outs, and / or targeted performance incentives.
 - For example, the primary focus of Managed Care Organizations since the early 1970s has been on reducing the utilization of emergency rooms and hospital inpatient admissions.
 - An IPA is also a fiscal intermediary between you, the provider, as a member of the IPA, and the MCO.
- Population health = fairly recent terminology that refers to an integrated system of healthcare service delivery covering all sectors of healthcare needs for a defined population of Plan members / enrollees.
 - Typically, a “Managed Care population” for healthcare delivery should be at least 10,000 lives in order to properly spread the risk associated with high cost / high need individuals.

Top 10 Things You Need To Know

2. Provider contracting with these primary Fiscal Intermediaries (MCO / IPA), who will stand in place of DOH via contract. The related contract negotiations will become extremely important in whether or not you will have success in a LTC Managed Care model.

- You will need to designate a multi-disciplinary Provider Contracting Team for your organization.
- Do not sign standard template contracts without reading them first. It will be rare for you to sign a “standard contract”.
- Many providers have already received and many have signed “template contracts” from MLTC Plans, Health Homes, etc.
- After reading a template contract, you can be assured that some modifications / addenda will be required.
- Remember that Managed Care is, at its core, a negotiated rate-based financial risk model – AKA insurance for a population of enrollees who you, the provider, does not control.

Top 10 Things You Need To Know

3. The initial shifting of financial risk for the LTC population is expected to be a transfer from DOH to the Fiscal Intermediary organizations (MLTCs).
 - MLTC plans are too numerous to mention here – FIDELIS, Excellus, MVP, VNA, ILS/HUMANA, etc. are the most active in the Upstate Market.
 - MLTC Plans have been approved for enrollment throughout 2013/14 by DOH.
 - Individual priorities should generally NOT ACCEPT financial risk.
 - Upstate is booming!
 - Please be aware that, at least initially, certain protection for providers related to existing rates (e.g., Clinic) has been provided for in the Managed Care transition process.

Top 10 Things You Need To Know

3. The initial shifting of financial risk for the LTC population is expected to be a transfer from DOH to the Fiscal Intermediary organizations (MLTC Plans) (Continued).

- Most common in the LTC provider arena will be the MLTC and/or IPA structures.
- That is, direct contracting as an individual provider with an MCO or jointly contracting through an IPA entity formed by multiple providers as a Regional Provider Network.
- There will be multiple Fiscal Intermediaries requesting your organization to sign a “Participating Provider Agreement” in their Provider Service Network.
- Because of provider rate protections mentioned above, be aware that in the initial contracting process (1-3 years), it is unlikely that individual providers will be subject to assuming any major degree of financial risk related to services provided.

Top 10 Things You Need To Know

3. The initial shifting of financial risk for the LTC population is expected to be a transfer from DOH to the Fiscal Intermediary organizations (MLTC Plans) (Continued).
 - Individual provider risks / incentives are difficult to manage on an individual provider basis.
 - That is why a Regional Provider Network entity, formed as an IPA, can be beneficial to your organization.
 - Can Leading Age sponsor/facilitate Regional LTC IPAs?

Top 10 Things You Need To Know

4. Therefore, it is likely that any shift of financial risk to individual LTC providers / IPAs will be delayed until 2015 / 2016.

- Prospectively, individual providers / IPAs can expect to receive a portion of what was Fee For Service rate reimbursement, which will then be based on service quality, efficiency, and desirable outcomes.
- Quality standards and targeted service outcomes, as defined by DOH and the MCOs, are anticipated to be used as the “Bible”.
- There will be various payment models developed by the Fiscal Intermediaries for purposes of paying individual providers or the IPA entity.
- Fundamental to the IPA entity structure is a “pooling” of risk to be spread across multiple providers who are IPA members. Providers must be careful in assessing the quality and cost of other providers who are members of the IPA.
- For those providers who participated in Worker’s Comp Self Insurance Trusts, you are already aware of the potential risks associated with “joint and several liability”.
- The payment models will move some portion of Fee For Service rate reimbursement towards P4P-targeted payment methodologies.

Top 10 Things You Need To Know

4. Therefore, it is likely that any shift of financial risk to individual providers / IPAs will be delayed until 2015 / 2016 (Continued).

- The IPA membership / contract structure does provide for more flexibility than a Worker's Comp Self Insurance Trust -- specifically, variable withholds for individual provider members of the IPA.
- However, I believe that individual LTC providers will continue to be reimbursed in the short-term based on either the published Medicaid rates or negotiated rates with commercial payors.
- During the initial transition phase, it is extremely important for individual providers or provider networks to develop creative / innovative alternatives to traditional service delivery modalities.
- Possible scenario: 92-98% = fee for service, 2-8% = performance-based compensation.
- Performance-based compensation / financial risk is typically funded by a provider withhold / financial risk pool based on claims submitted during each year.
- IPAs, at this point, are not subject to Article 44 Insurance regulations, as long as...clinical and financial integration processes are implemented.
- In my opinion, the State (DOH) is open to and looking for creative solutions from providers that satisfy the State's Managed Care objectives.
- That is why the State recently received approval for \$8 billion of Federal funds for the Delivery System Reform Incentive Program (DSRIP) February 2014.

Top 10 Things You Need To Know

5. The transfer of Care Coordination / Case Management responsibilities from the provider to the Fiscal Intermediaries (MLTCs) is a significant structural and operational change for every provider.

- Care Coordination / Case Management will impact on each and every program service component for every provider.
- The State's objective of a fully integrated delivery system begs the question of how and whether LTC providers should be linking to primary referral sources (e.g., health system discharge planners, home care providers, etc.). I believe that linkage to primary care is a must but gaining traction and acceptance in this area may be difficult in the initial stages of LTC Managed Care.
- The fundamental expectation of Medicaid Managed Care is to shift focus from what individuals "Want" and "Need" to what services are "appropriate at an affordable cost". Affordable cost is determined by negotiation between the MCO and individual providers / IPAs.
- The transition of Care Coordination / Case Management by providers to Fiscal Intermediaries will continue to be a major challenge, especially during the transition period.

Top 10 Things You Need To Know

6. As a result, this fundamental change moves the LTC population from provider control over service needs to a system that provides an external / independent (Care Coordinator/MLTC Plan) assessment of what the individual “needs”.

- Dual eligibles are a focus area of high cost.
- State intends to use Quality and Service Metrics for maintaining objectivity in determining service needs.
- Inevitably, a certain degree of subjectivity will be required.
- For example, in a medical model, should a patient receive an MRI vs. CT Scan vs. PET Scan or who is entitled to joint replacement surgery based on the age of the patient.
- It is interesting to note that after decades of Managed Care implementation, the focus is still on avoiding emergency room visits and inpatient admissions / re-admissions. As you all know, these facility-based services are typically higher cost and not viewed as cost effective in relation to community-based (Adult Day and residential/custodial) services.

Top 10 Things You Need To Know

7. The fundamental programmatic change for providers will, as the State suggests, require “transformational change” throughout your organization.

- Providers, over time, will become more focused on cost, cost effectiveness, and appropriate need for frequency of service delivery.
- Managed Care principles will result in inherent conflicts of interest and ethical issues for providers and particularly clinicians and administrators.
- These conflicts of interest and ethical issues will significantly increase your risk management and compliance program initiatives.
- Clinicians and service providers may require extensive re-training and education related to the revised approaches to individual resident service delivery and service modalities.

Top 10 Things You Need To Know

8. Individual LTC providers should never accept capitation rates (fixed price contract amount for a specific population of enrollees).

- In the final analysis, rates / amounts paid by DOH on a Per Member Per Month (PMPM) to the MLTC Plan will determine the amount of “pain or pleasure” that providers will experience from a financial perspective.
- Historical value of adjudicated claims should not be either the State’s or the provider’s reference point for determining PMPM amounts.
- That is because we know that rates currently being paid may bear no relationship to the actual cost of the service being delivered.

Top 10 Things You Need To Know

8. Individual LTC providers should never accept capitation rates (fixed price contract amount for a specific population of enrollees) (Continued).
- Smaller providers, linking with larger providers, should consider formation of a Regional Network (i.e., either an IPA or a joint contracting LLC).
 - As a provider, your primary goals in Network Participation should be to achieve a strategic position that:
 - Makes you too big to ignore by the MCOs.
 - Makes you too big to exclude from MCO provider networks.
 - The network IPA provides its members with additional negotiating leverage.

Top 10 Things You Need To Know

8. Individual LTC providers should never accept capitation rates (fixed price contract amount for a specific population of enrollees) (Continued).

- LTC providers want to be paid at or above cost for all services provided to MCOs.
 - MCOs want to pay providers the lowest amount that the LTC provider will agree to with the most favorable MCO terms and conditions.
 - After all, MCOs need to cover their administrative costs and targeted return on their investment (profit / capital reserves).
- For all of the preceding reasons, each and every provider needs to determine whether it wants to negotiate individually or in collaboration with a provider network through an IPA structure.

Top 10 Things You Need To Know

9. The State's Medicaid Redesign Team and its "Triple Aim" anticipate cost efficiencies together with improved health and service outcomes. This expectation will require each provider to assess its strategic positioning with respect to future service delivery.
- As a result of the foregoing, major structural and operational changes will be required.
 - Every provider Board and Management Team should be asking and answering the following questions:
 - Does your organization want to maintain individual autonomy in the next 3-5 years or is it more feasible to merge with or be acquired by another organization? (That is, is your service niche exceptional or is your organization already too big to ignore as a LTC provider?)
 - Depending upon the answers to the foregoing questions, contracting decisions regarding network participation (e.g., IPA) and negotiating favorable payment rates / incentives will be of paramount importance.

Top 10 Things You Need To Know

9. The State's Medicaid Redesign Team and its "Triple Aim" anticipate cost efficiencies together with improved health and service outcomes. This expectation will require each provider to assess its strategic positioning with respect to future service delivery (Continued).

- Those areas of highest priority are:
 - Cost accounting systems for individual high-cost consumers. These software applications may not yet exist at the level of sophistication necessary to truly "Manage Care".
 - Electronic Health Records (EHR / EMR) will be a necessity for all program service components.
 - Restructuring your billing and accounts receivable systems to accommodate revised contract payment methodologies (e.g., incentive payments for achieving performance goals, P4P).

Top 10 Things You Need To Know

9. The State's Medicaid Redesign Team and its "Triple Aim" anticipate cost efficiencies together with improved health and service outcomes. This expectation will require each provider to assess its strategic positioning with respect to future service delivery (Continued).

- If autonomy is not an option, begin the process of evaluating affiliation and merger options with other providers.
- An effective alternative to merger / affiliation may be the formation of and participation in a regional IPA.

Top 10 Things You Need To Know

10. Based on my 30+ years of experience in working with Managed Care models, insurance companies, and being certified as a Managed Care Professional, every provider must be aware of “The Five Rs” identified and originated by this presenter:

- Restricted Access, AKA Challenges to Service Eligibility
- Relocation of Service Delivery Sites, searching for lowest cost of care
- Rationing of Services Through Care Coordination – clients needs vs. wants
- Redistribution of the Health and Human Services Fiscal Budget (\$\$\$)
- Reduced End of Life Care and aging demographic will result in more Palliative vs. Curative service delivery (e.g., reduced Emergency Room utilization and inpatient admissions)

Structural Alternatives for Managed Care Contracting

- The previous Top 10 answered the question of WHY a modified organizational structure is necessary for Managed Care contracting.
- The previous slides also addressed HOW an individual LTC provider needs to assess its Strategic Positioning with respect to Managed Care plans.
- The following slides will answer the question, WHAT alternatives are available for providers to consider in their assessment of Strategic Positioning with Managed Care Organizations?

Types of Independent Provider Associations (IPAs)

- There are three distinct structural alternatives for an IPA entity, as follows:
 - 1) Independent
 - 2) Captive – typically owned/controlled by the MCO or a Health System
 - 3) Partnership between MCO and IPA entities
- Depending upon facts and circumstances, any one of the three alternatives listed above may be appropriate.
- Provider control is greatest in the Independent model IPA.
- Depending upon the attitude and relationship between the MCO and the individual providers, the Captive and Partnership models may be desirable or not feasible.

Characteristics of Each IPA Model

- Independent:

- Formation of the independent IPA is a grass roots effort of the providers who are also members of the IPA.
- Board representation consists only of representatives from participating provider members of the IPA.
- Decision-making authority rests with the IPA Board that is initially appointed by the IPA provider members.
- Independent taxable or non-taxable entity, depending on structure and objectives.
- Contract negotiations with MCOs are managed directly by the IPA Board, its independent legal counsel, and individuals designated with contract negotiation authority.
- Primary advantage for the MCO is that through a single signature, a regional network of providers can be MCO network participants without having individual negotiations with each provider.

Characteristics of Each IPA Model

- Independent:
 - Single signature contract authority by the IPA Board is powerful from a negotiation and leverage perspective.
 - In order to pass legal requirements and anti-trust regulations, IPA cannot be formed for the sole purpose of negotiating rates.
 - Rather, in addition to rate negotiation, the IPA must assume some degree of financial risks and/or performance-based incentives as a condition of the contract with the MCO.
 - In order to effectively function as a joint network entity of multiple providers, there must be some evidence of “clinical and financial integration” among IPA provider members.

Characteristics of Each IPA Model

- Captive:

- In a captive IPA, the IPA is typically owned, operated, and controlled by the MCO.
- This is the preferred model from the MCO perspective, since it provides that decision-making authority, rate determination, and performance targets are under the direct control of the MCO / Plan Management.
- In a captive IPA, it is a given that periodic contract negotiations are unnecessary, as the MCO typically makes and implements contract decisions.
- That is, you as the provider are offered a “Participating Provider Agreement” that enables you to participate in the MCO network.
- However, in signing the typical Participating Provider Agreement, you are transferring the authority and responsibility for almost all decision making to the MCO, with the exception of actual service delivery and related service documentation.
- In a captive model, it is common for the majority of service providers to be employed directly by the lead / largest provider (e.g., hospital / health systems being the most common)
- If a hospital / health system is not directly involved in owning the captive IPA, then the IPA is typically owned / controlled directly by the MCO.

Characteristics of Each IPA Model

- Partnership:

- Depending upon facts and circumstances, a partnership ownership structure between the MCO and the IPA members may be viewed as the most desirable structure for an IPA.
- However, partnerships, like marriages, are prone to differing objectives and frequently divorce.
- A partnership IPA structure requires a symbiotic relationship between the MCO and the individual IPA provider organizations. Mutually agreeable common objectives are a requirement.
- While this structure is desirable, it is also the most difficult to implement successfully over the long term.
- In the partnership model, there is an inherent conflict between the MCO's desire for profitability and the IPA provider member organizations' desire to provide the best quality services with the best possible results at a reasonable rate to the clients being served.

Characteristics of Each IPA Model

- Partnership:

- A partnership IPA model typically requires 50% ownership and control by the MCO and 50% by the IPA provider organizations.
- It is well known that 50-50 control models do not work well when a dispute or disagreement occurs.
- In order for a partnership model with 50-50 ownership/decision-making to be successful, there must be a timely, efficient, non-judgmental, and independent arbitrator available to make binding decisions for the IPA owners / members.

Forming an IPA

- Assuming that you have a critical mass of regional providers interested in forming an independent IPA, please contact me or Janine to discuss the critical steps and decisions that need to be made for successful formation and implementation.

Managed Care Contracting

- Background and Experience
 - Since 1985, I have negotiated Managed Care Contracts directly with a number of insurance companies including Excellus, Aetna, MVP, Fidelis, and more
 - Since 1975, I have represented the interest of all types of Health Care and Human Service providers
 - I have always served on the provider side in my project consulting and Managed Care contracting negotiations

Managed Care Contracting

- TOP TEN primary issues to be addressed by providers in every LTC contract negotiation
 1. What payment rate will the LTC provider be paid?
 2. What services are covered under the LTC contract?
 3. What, if any, services can be billed separately or to the resident directly?
 4. What, if any, financial risk is being transferred to the LTC provider based on the contract terms?

Managed Care Contracting

- TOP TEN primary issues to be addressed by providers in every LTC contract negotiation (Cont'd)
 5. What performance incentives or penalties are included in the LTC contract?
 6. How frequently can the LTC provider bill for services provided under the contract?
 7. What are the expected payment terms from the MLTC to the provider once a “clean claim” has been submitted?

Managed Care Contracting

- TOP TEN primary issues to be addressed by providers in every LTC contract negotiation (Cont'd)
 8. What requirements or initiatives are planned / contracted for by the MLTC organization?
 9. How will the payment rate for services be determined and when will it be adjusted? (i.e., What Medicaid rate will be used for payment?, appeals, published rates, etc.)
 10. What is the dispute resolution process to be followed?

Managed Care Contracting

- TOP TEN Contract Issues to be Negotiated –
 1. BEWARE of standard contracts and contract templates
 2. NEVER accept or sign a standard/template contract without some addendum or changes specific to your organization
 3. ALWAYS require a supplemental schedule that specifically defines covered and non-covered services
 4. ALWAYS be sure that the payment rates are specified, agreed to, and provide for periodic renegotiation

Managed Care Contracting

- TOP TEN Contract Issues to be Negotiated (Cont'd)
 5. AVOID “evergreen renewal provisions” in almost all situations
 6. SPECIFY termination and withdrawal provisions that are favorable to the LTC provider
 7. DEFINE the process and approach to be used to confirm/verify patient/resident eligibility

Managed Care Contracting

- TOP TEN Contract Issues to be Negotiated (Cont'd)
 8. Do you need to sign this contract and be a participating provider?
 9. What are the specific duties and responsibilities of the MLTC organization?
 10. How will the MLTC organization reduce/avoid LTC resident admissions?

Managed Care Contracting – Typical Contract Clauses

1. Definitions
2. Responsibilities of the LTC Provider
3. Responsibilities of the MLTC Plan
4. Quality Assurance and Utilization Management Requirements
5. Billing, Claims Processing, and Payment Arrangements

Managed Care Contracting – Typical Contract Clauses

6. Adherence to ethical and religious directives – Fidelis only
7. Medical/Financial records and reports
8. Contract term and termination provisions
9. Requirements for insurance coverage and indemnification clauses
10. Disclosure of participating network provider – use of facility name

Managed Care Contracting – Typical Contract Clauses

11. Notice, dispute resolution, and regulatory compliance provisions
12. Medicare advantage provisions if applicable
13. Schedule 1 – specifics of program participation
14. Schedule 2 – specifics of services provided and related payment rates
15. Schedule 3 – excluded services and precertification requirements

Managed Care Contracting - Negotiable Terms

- Program service modality/reconfiguration of how and what services are provided
- Development and implementation of clinical / program service protocols with provider input
- Administrative structure of the Managed Care Organization (MCO)
- Who controls the dollars related to services provided under the Managed Care Contract
 - Who controls the determination of services to be provided and eligible benefits (e.g., Care Coordination)
 - Who controls the billing and payment processes (MLTC duties and responsibilities must be well defined)

Managed Care Contracting - Negotiable Terms

- Governmental Audit Recoupment Rights and Protocols (OMIG)
- Need for regulatory relief on providers (e.g., level and frequency of service documentation)
- Developing the appropriate linkage and standards for Care Coordination/Case Management with specific definition of duties, responsibilities, and authority

Managed Care Contracting - Negotiable Terms

- Achieving the proper balance between traditional LTC service modalities in comparison to traditional Managed Care cost and utilization controls. In other words developing specific guidelines for who is entitled to what services, including when and how services are provided (e.g., emergency room visits)
- Provider input in developing collaborative relationships with the MLTC organization. In other words, can the LTC limit insurance company responsibilities (e.g., administrative duties, Care Coordination/Case Management and claims processing)
- Provider input into decisions relating to provider fiscal stability/service quality and developing an organized approach to right-sizing provider capacity in relation to service demands / volumes

Managed Care Contracting - Non-Negotiable Terms

- Adjustment to existing or agreed upon payment rate without having adequate data and support
- What is the “actual cost” of providing services to those individuals that are identified as high cost utilizes patient services
- Providers should not accept or consider a financial risk contract without significant contractual protection
- In no event should providers accept any financial risk/performance incentive without having reliable service data and related costs
- MLTC organizations have a combined responsibility for contracting with a certain number of providers to ensure appropriate access

Managed Care Contracting - Non-Negotiable Terms

- Providers should inquire regarding other participating facilities in the MLTC network panel
- Determine how and whether your traditional admission policy will be affected by the MLTC
- The MLTC organization should provide the LTC with their anticipated plan and process for future access to LTC services
- That is what, if any, upside benefits will be derived by the LTC facility in signing the contract?

Questions and Answers

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