

A Checklist For Reviewing Managed Care Contracts

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Abstract

Today, in response to the demands of managed care, licensed health providers have become increasingly dependent upon managed care contracts with managed care organizations to market their services. These contracts, while contributing to the provider's patient base, introduce new legal, contractual, and financial risks that the provider must consider. This article reviews important contract provisions that must be clarified, revised, and finalized to the satisfaction of the provider and his or her legal counsel, before "signing on the dotted line."

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DISCLAIMERS

This article is not intended as a complete discussion of the legal issues associated with managed care contracting, nor are they intended as specific legal advice. The views expressed in this article are solely those of the author and result from the author's application of legal principles in the ongoing review and negotiation of various contractual relationships involving licensed health professionals and managed care

organizations. Readers should consult legal counsel for advice in dealing with specific legal issues.

A CHECKLIST FOR REVIEWING MANAGED CARE CONTRACTS

Contracting for the delivery of health care services is not a new concept. Hospitals, physicians, advanced practice nurses, and other licensed health professionals have been contracting directly with hospitals, clinics, and industry for many years. Today, in response to the demands of managed care, these same hospitals, physicians, advanced practice nurses, and licensed health care providers have become increasingly dependent upon managed care contracts with health plans, health maintenance organizations, and various other forms of managed care organizations (hereinafter collectively referred to as "MCOs") to market their services.¹ These contracts, while contributing to the provider's patient base, introduce new legal, contractual, and financial risks that must be taken into consideration during the negotiation process.^{1,2} Whether contacting directly, or through a MCO, providers should understand the conditions associated with the assumption of these risks and the relationships created as a result of these contracts.

THE CHECKLIST

There are certain provisions in any managed care contract that the provider and his legal counsel must carefully consider. Although this article is not exhaustive, it provides a general framework for health care providers and their legal counsel

to use in reviewing contracts in order to identify those provisions that should be clarified, revised, or otherwise deleted from the agreement before the parties agree to “sign on the bottom line.”

PARTIES

In considering any prospective contractual relationship with a MCO, the provider should obtain and review all available information from the MCO and other independent sources.^{1,2} In reviewing these materials, it is important to determine how long the MCO has been in operation and whether it is a financially stable and solvent legal entity. The provider should also interview other persons who have had relationships with the MCO, either as patients or as participating providers to learn more about the organization’s strengths and weaknesses. Finally, the provider should examine the MCO’s member and provider disenrollment rates. If one or more of these rates are high, it may mean that those involved with the MCO, patients and providers alike, are not satisfied.^{1,2}

The provider should also confirm the identity of all parties to the proposed agreement, including any third party plans or payors to whom the MCO serves as a third party administrator. Unless otherwise agreed to by the parties, the provider would be expected to provide health care services to enrollees of each of these plans under the terms of this Agreement. In turn, the provider should also request specific information about each of the payor plans and their particular rules and procedures, again to allow for compliance with these many expectations during the term of the relationship.^{1,2}

KEY TERMS

One of the most important, and often overlooked, sections of the managed care contract is the definitions section. Such terms as covered services, covered persons, emergency, and medically necessary, should be adopted by the parties as part of the negotiating process and used consistently throughout the final contract and any related MCO policies and procedures.^{1,2}

PROVIDER OBLIGATIONS

At the very least, the contract should state that the provider is not obligated to provide any services under the contract that it does not ordinarily and customarily provide to its patients who are not members of the contracting MCO and its affiliate plans. In addition, the parties may want to consider adding an addendum to the contract that specifically lists all services, or types of services, that are covered by the MCO and the plans. Finally, the provider may want to add a paragraph providing that if, in the future, the provider elects to limit or discontinue certain services, the provider may do so without penalty, provided appropriate notice is given to the MCO according to the contract’s terms.^{1,2}

With regards to regulatory compliance, it is not uncommon for managed care contracts to include a provision that requires the contracting health care provider to maintain all licenses, registrations, permits and certifications required by law to perform the services set forth in the contract.^{1,2} The provider may also be required to maintain certain levels of professional liability insurance during the term of the contract.^{1,2} MCOs may also require the provider to give prompt notice of any material changes in the provider’s legal or professional status. While agreeing to these provisions, it is reasonable for the contracting provider to similarly require the MCO to maintain those licenses and permits required of the MCO by law, as well as certain levels of both general and professional liability insurance, as part of the MCO’s obligations under the contract.

MCO OBLIGATIONS

All managed care contracts should include language that requires the participating health care provider to comply with all bylaws, rules, regulations, policies, and procedures of the MCO and its various plans, particularly those concerned with credentialing, peer review, precertification, verification, quality and utilization review, grievances, and appeals.^{1,2} To begin, the provider should obtain and carefully review a copy of all such materials in order to make sure they are consistent with the provider’s own operating procedures. A

copy of all such materials should be incorporated as an attachment to the final contract at the time it is executed by the parties.

To properly anticipate future changes, language should be included in the contract that requires the MCO to inform the provider at least 30 to 60 days in advance of any proposed amendments to these MCO bylaws, rules, regulations, policies and procedures, which allows the provider an opportunity to review, comment, and adapt as possible to the proposed changes.^{1,2} In the event the proposed amendments are entirely unacceptable, the provider may be able to terminate the arrangement altogether if the contract offers a termination “without cause” provision.

COMPENSATION

A key element of any managed care contract is the provider’s compensation for services.^{1,2} First, the contract should clearly state how and when the provider is to be paid. Similarly, the provider should clearly understand the administrative requirements of submitting claims and the timing of receiving payment. For example, the time period within which a provider must submit claims must be clearly stated. Second, the particular forms used to submit claims must be identified by name. Third, all arrangements with regards to the coordination of benefits and late payments must be carefully spelled out in the contract. Finally, since providers don’t contract directly with the various payors and plans administered by the MCO, language must be added to the contract that requires the MCO to use its “best efforts” to ensure timely payments by these third party payors and plans.

A managed care contract may offer different types of payment.² Common types of payments include discounted fee-for-service, per diem, per case, percentage of premiums, and capitated arrangements. Any of these payment methods can be satisfactory, but each may pose problems as well. In today’s managed care environment, the most common compensation options for licensed professionals are the discounted fee-for-service, per

case charges, and capitation. Under a discounted fee-for-service arrangement, covered services are compensated at a discount of the provider’s usual and customary charges. Providers are more apt to accept these discounts in return for an increased patient volume as a result of this arrangement with the payor. Under a per case or visit charge arrangement, the payor compensates the provider a predetermined rate for each episode of care provided. Because discounted fee-for-service and per case charges can arguably encourage a provider to increase the level of services provided, payors often implement strict rules or incentives to restrain any such resulting increases. Under a capitation arrangement, the provider, typically a primary care provider or “gatekeeper,” is compensated for covered services based upon a fixed payment that is often referred to as a “per member per month” amount. Unlike the discounted fee-for-service or per case charge methods, capitation arrangements typically presents a heightened case management or “gatekeeper” obligation, and an increased financial risk to the provider.

Finally, some contracts involve withhold pools which are funded by a MCO’s deduction from each participating provider’s payment. These amounts are usually set aside in pools to pay for inpatient or other unanticipated patient-related costs. The provider is at risk if the cost of services rendered to covered persons is higher than expected. When such costs exceed the MCO’s budget, part or all of the withhold pool may be forfeited by the provider. If the costs do not exceed this ceiling, part or all of the withhold pool may be returned to each participating provider at the close of the fiscal year.

In reviewing any managed care contract, be alert for any provisions that allow the MCO to “rebundle,” or add to the covered services included in a single bundled fee, or amend any terms of the compensation arrangement at will. To accommodate the provider’s fiscal planning, all material terms of the Agreement, particularly those having to do with compensation and payment, should only be modified at the

time the contract is renewed, or with the prior express consent of both parties to the contract.

Managed care contracts often prohibit, or otherwise limit, the provider from seeking payment directly from members of the MCO and related plans. The provider should determine the applicable laws that control when, how, and under what circumstances the provider may seek particular payments from either members or the MCO when the provider is not otherwise reimbursed for services rendered.

INSURANCE, INDEMNIFICATION, NOTIFICATIONS

Managed care contracts often contain clauses in which one of the parties to the contract agrees to hold the other party to the contract without responsibility, or “harmless,” thus assuming liability for damages arising out of the relationship. MCOs that use these clauses typically try to get providers to assume responsibility for any medical malpractice claims that may be filed against the MCO.^{1,2} Providers should be aware of the existence of these clauses and their potentially damaging effects. Moreover, these “hold harmless” clauses will not necessarily appear in a contract under a clearly distinguished heading. Rather, they may be hidden in the contract indemnification section, the miscellaneous provisions section, or in some other part of the contract.

Therefore, before signing a managed care contract, the provider should have his or her attorney review the agreement, or at a minimum, any hold harmless clauses that might try to shift liability from the MCO to the provider. The provider may also contact his or her professional liability carrier and have its attorney review the contract language to make sure it does not commit the provider to greater liability than the insurance coverage permits. Many insurance carriers offer such reviews as a courtesy to its policyholders. As well, in reviewing a draft of any such contract, the provider should feel free to cross out and initial any changes to the contract that are made. Until all of the terms and conditions of the contract are accepted by the parties, the contract is not binding.

As the provider and his attorney gain experience with these contracts, they will find that many of these provisions are negotiable.

In all fairness, a party may be required to indemnify for losses that are its fault, but a party should not agree to identify losses that are not its fault. Of course, causation might be difficult to determine. Thus, the parties may prefer to limit indemnification to those situations where one party is “primarily” or even “solely” at fault. In any case, a party’s obligation to indemnify under a contract should always be contingent upon reasonable notice and an adequate opportunity address any claim or demand involving the parties.

RECORDS

MCOs frequently claim ownership of all confidential and proprietary “information” related to the provider’s delivery of services under the contract. First, any such references to “information” must be defined and agreed to by the parties in advance. Moreover, all such provisions, particularly with regards to ownership, retention, and access, must be carefully reviewed and revised as necessary, taking into consideration applicable federal and state laws and regulations and the parties’ own policies and procedures.^{1,2}

TERMINATION

There are three primary ways to terminate a contract prior to its natural expiration at the end of the contract’s term.^{1,2} First, the contract may be terminated by a mutual agreement of the parties to the contract. Secondly, the contract may be terminated “without cause,” which allows either party to “walk away” from the deal after the necessary notice required by the contract has been given to the other party. Although each of these methods allow the parties flexibility in terminating the contract before its completion, one or both of the parties may be reluctant to include such provisions, depending on how much the parties may depend on one another for patients or services.

The contract should also allow either party to terminate

“with cause,” in the event the other party fails to comply with its many promises and obligations as they are set forth in the contract. Although a 30-day “cure” period is often included to encourage the parties to resolve a party’s breach or default prior to a termination “with cause,” an automatic termination provision may also be included to address those situations when a party becomes insolvent, convicted of a health care crime, or loses insurance coverage or a regulatory license as required by law.

CONCLUSION

The foregoing issues are some of the more important ones that the provider and his or her legal

counsel should keep in mind during the review and negotiation of any managed care contract. Each contract is unique and should be reviewed individually, in its entirety. At all costs, providers should avoid simply signing and filing contracts without careful review, given these contracts will likely require the provider to assume new legal, contractual and financial risks in today’s managed care environment.

References

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