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Managed Care Contracting: What's New, What's Important?

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Introduction

Contractual relationships between healthcare providers and managed care organizations (MCOs) are a cornerstone of the payment system for commercial healthcare. In recent years, however, managed care relationships have also swept into Medicare through Medicare Parts C and D, Medicaid (as many states turn to a managed care model), and even workers' compensation in some states, including Texas.

Traditionally, MCOs have "template" provider contracts that will serve as the starting point for any negotiation. Although providers are not the drafters, providers will want to carefully review these templates to, at a minimum, fully understand the terms and comply. A provider should also, however, be prepared to negotiate with payers on items of important to its goals and organization.

This paper briefly reviews key areas of interest to both providers and MCOs, from the provider perspective. This is not a comprehensive treatment of all managed care contracting issues, but certain, more comprehensive resources are listed at the end.

Scope of Contract

Some MCOs organize their template contracts by line of business (Medicare, Medicaid, HMO, PPO, etc.) while others have one master contract with lines of business attachments at the back. Either way, providers will want to understand the scope of the contract—the fundamental questions being:

- Who are the parties to the contract?
- To what products (and corresponding patients) does the contract (and its rates) apply?

Covered Party Issues

As MCOs and providers grow and affiliate, parties sometimes disagree on who may access a contract. This issue falls into both the "what's new" and "what's important" categories as the healthcare industry continues through a wave of acquisitions and consolidations on both the MCO and provider sides.

Providers will want to carefully consider key definitions, including "Payer" (or "Client"), "Affiliate," and "Plan," as well as look at any terms in the contract that address adding payers, products, or affiliates to the contract.

Providers will also want to consider whether the contract adequately addresses growth on the provider side. Can new service locations, healthcare professionals, or facilities be added to the contract? What is the process for such additions? Are there any geographic or other restrictions on such additions?

> ***Sample Language:*** In the event Provider or its Affiliate begins providing services at any additional location(s), either by establishing such location(s) itself, or by acquiring, merging, or affiliating with an existing provider of services, such additional location(s) will become subject to this Agreement upon Provider's request. [*Physician groups may want to consider similar language for addition of individual physicians, along with language obligating the MCO to promptly credential.*]

Covered Product Issues

After the parties are settled, providers will want to understand what products are covered and if and how products may be added to the contract.

> ***Sample Language:*** Provider will participate in only the Plans and Plan designs listed in Attachment XX, attached hereto and made a part hereof. Plans must provide Members with a meaningful incentive to utilize Provider, such that Members' copayments, deductibles, and coinsurance are at least 20% less for non-emergency Covered Services received from Participating Providers versus non-Participating Providers.

In Texas, providers will also want to consider the impact of the relatively recent addition of Chapter 1458 to the Texas Insurance Code. This statute took effect September 1, 2013 and is generally design to address the "silent PPO" problem—i.e., where a provider's contract rates are accessed by a third-party payer without the provider's knowledge. Among other requirements, Chapter 1458 and the corresponding regulations require MCOs to specify or reference fee schedules for each separate "line of business," which is defined to include individual and group PPO plans, individual and group EPO plans, individual and group HMO plans, Medicare Advantage plans, Medicaid managed care, and CHIP.[1] MCOs subject to Chapter 1458 also may not sell, lease, or otherwise transfer provider contract rates without the express authority of and prior adequate notification to the provider.[2]

Payment and Pricing

Many providers will focus on the contract rates, since this is the "bottom line" in many ways, and the term most frequently negotiated at the individual contract level. But as important as a "good" contract rate is, providers should also consider other payment terms that can also impact the bottom line.

[1] Tex. Ins. Code § 1458.101(a),(e).
[2] *Id.* § 1458.101(b).

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