

TIPS FOR NEGOTIATING MANAGED CARE CONTRACTS

Emergency physician groups seem to be contracting with managed care organizations (MCO) more and more these days. If it has been years since your practice contracted with an MCO, you may be tempted to gloss-over the pages upon pages of unfamiliar legalese in the agreement. Or, you may be inclined to focus solely on the financial terms, dismissing the remaining provisions as mere boilerplate. Taking either approach is like walking blindfolded into a minefield—you may not notice a problem until it's too late!

With that risk in mind, we thought it would be helpful to summarize some of the key issues we see during managed care agreement negotiations. The idea here is to help you spot potential problems in the contract, and hopefully, be able to better articulate why those provisions should be modified. Before we begin though, here is our lawyer-mandated disclaimer: This document should not be a substitute for qualified, professional legal counsel. Now, with that done, let's begin.

1. Understand the Basics.

After you have read through the agreement, a good place to start your analysis is by asking the following three basic, yet crucial, questions: (1) how long am I going to be locked into the agreement, (2) how do I get paid, and (3) how do I get out of the agreement? We discuss each of these questions in more detail below:

- a. Duration. Obviously, it is importantly to know the length of the term of the agreement. In our experience, most MCO contracts provide for a one-year term, with an automatic one-year renewal period commencing on the first anniversary of the agreement. Usually, the parties have the right to terminate the contract within a certain amount of time before the anniversary/renewal date. Thirty days seems to be pretty standard, but don't stop there if that is all you see. Ask for the right to terminate the agreement if you and the MCO are unable to agree upon a revised fee schedule for the renewal term within some period of time greater than thirty days before the expiration of the initial term. For example, the contract could say that if by the 90th day before the last day of the initial term, the parties cannot agree on the fee schedule for the renewal term, you can elect not to renew. This is particularly helpful because the fee schedule is usually the sticking point in agreement renegotiations. With this added feature, if you terminate based upon your and the MCO's failure to come to terms on a fee schedule for the renewal term, you'll have 90 days (instead of 30) to consider things like: (1) how to handle communicating to the hospital that you are not renewing this MCO agreement, or (2) what other MCO group or groups should you contract with during the next year.

- b. Termination Provisions. Since you cannot predict what the future holds, having the right to get out of the contract under numerous circumstances is very advantageous. Ideally, your agreement gives you the right to terminate for any reason at all by giving 30 days notice to the MCO. However, good luck getting this provision. The MCO is probably going to instead, insist that you can terminate only if the MCO commits some "material breach" of the agreement. If this sounds okay

in concept to you, that's fine, but it isn't time to move on to the next contract item yet. If you did, it would simply set the stage for a fight later on over what the heck "material breach" means. To avoid this battle, be sure your agreement spells out what a material breach could include. Some examples are: (1) if the MCO is delinquent in paying you an aggregate reimbursement of at least \$[insert figure] or more for some period of time, excluding amounts disputed in good faith by the MCO, (2) if the MCO becomes bankrupt, (3) if the number of enrollees in the MCO's plan drops below a certain amount, (4) if the hospital where the group operates terminates its agreement with the MCO, or (5) if the MCO loses its license necessary to operate as a managed care provider. In sum, be sure to spend some time thinking about this one if you are not fortunate enough to obtain the 30-day at-will termination provision discussed above.

- c. Compensation. Since compensation is the topic usually garnering the most attention from commentators, we will not devote much time to it here. However, there are a couple of things to remember: First, if you base your fee on a multiple of Medicare reimbursement, be sure you know how "off-list" services for which Medicare does not pay will be handled. Many groups request a default or backstop rate for these services. Second, if your fees are to be based on a percentage of your standard charges, be sure to address the circumstances under which you may increase your charges. The last thing you want is for your fees to be carved in stone while market rates climb.

2. Watch Out for Silent PPO/Lease Issues

A critical, but often overlooked provision in managed care contracts involves the MCO's right to "sublease" the agreement and its fee schedule to other groups. An example of how this plays out will be helpful to understand the concept: Imagine that your group signs a contract with ABC Insurance that contains a discounted fee schedule. Imagine next that Joe Patient receives treatment at your facility for heart failure. His file indicates that his insurance provider, XYZ Insurance, is out-of-network, so your billing company sends XYZ a statement for the full procedure charge. XYZ responds by paying the exact discounted allowable for this procedure listed in the ABC Insurance agreement. If you noticed this oddity, you might wonder what just happened.

As it turns out, when Joe's out-of-network insurer, XYZ Insurance, received your bill, XYZ began shopping around for a discount. In doing so, it found ABC Insurance, paid them a fee and was able to treat Joe Patient as an enrollee under the ABC Insurance agreement. ABC Insurance can do this by virtue of how it defined "Payor" under the managed care agreement. That is, by defining the term broadly to include any entity that is contracted with ABC Insurance, ABC can simply assign its rates to XYZ such that Joe can take advantage of the discounted rates you negotiated with ABC. Sound sneaky? It is. In fact, many states, like Texas, have prohibited the so-called "Silent PPO" practice. However, other states still allow it. If you live in one of these states, be sure that your agreement defines "Payor" (or

whatever definition is used to represent the MCO) in the most narrow way possible. Suggested language reads as follows: “Payor means the MCO, any Affiliate of the MCO and any self-funded employee benefit plan that uses the MCO as an administrator”. You would also want to then define “Affiliate” as “any entity directly or indirectly controlled by, controlling or under common control with, a party, but only for so long as such control shall continue, control meaning the majority voting power.”

3. Request a Workable Claims Deadline

Another important contract term to understand in the managed care agreement is the claims deadline. This is the deadline by which you must submit a claim to the MCO in order to receive reimbursement. At a minimum, request 120 days. Sometimes, the MCO will include a provision eliminating reimbursement altogether if the claim is submitted past this deadline. Don't go for that. It's simply too draconian. Instead, counter with an offer to accept a penalty based on some deduction from the total reimbursement payable, calculated as a percentage of the total claim. For example, a claim submitted a month late might trigger a 15% reduction in your payment. If the claim is two months late, reduction doubles. You get the idea.

Also relevant to the subject of claim submissions is the fact that some agreements will permit the MCO to retroactively contest claim payments, often years after the payment was made. This can be difficult to manage for most providers, since records of three or four year-old claims may no longer be available, or if they are available, they may be difficult to locate. For these reasons, request that the MCO only be able to retroactively contest claims for a period of one year following payment.

4. Look Closely at Provisions about Law Changes

Often, a managed care contract will state that the MCO has the unilateral right to update the contract to accommodate any changes in applicable federal or state laws. While this may seem harmless, consider new laws that undermine the value of your practice being in the agreement in the first place. For example, what if your state legislature mandates that out-of-network insurers must pay the entire ER bill, as a contentious 1997 court case did in Washington state. If this occurred in your state, you would not want to be locked into accepting lower rates under your managed care agreement. What about a new state law requiring out-of-network commercial payors to pay rates according to a periodically published, statutorily-mandated fee schedule? This has been proposed recently in a number of states. If those statutory rates were more than the rates contained in your managed care contract, you would probably want out of the agreement ASAP.

In short, with healthcare laws changing almost daily, you'll want to be sure that those new laws don't adversely affect the assumptions upon which your contract was initially based. Therefore, you should request language in the agreement providing that any changes to applicable laws that materially alter the contract should first be evaluated by both parties. If the parties mutually agree, the agreement may be amended to reflect those laws. On the other hand, if the parties cannot agree upon the terms of the contract in light of the new laws, then either party should have the right to terminate. As for what “materially” should mean, try tying some dollar figure to it.

5. Modify Offset Provisions

Managed care contracts will sometimes contain provisions allowing the MCO to withhold reimbursement payments to the provider for amounts it believes the provider owes the MCO. These usually land in the back of the agreement under the “Miscellaneous” provisions. Because most ER physician groups are sensitive to monthly cash shortages, a significant offset could be particularly painful to your group’s practice. For that reason, try having the provision scrapped entirely. If the MCO refuses, demand that the MCO must first provide written notice of the dispute to you, along with a detailed explanation of the problem within 15 days after its receipt of the claim. That way, whatever their dispute is, you and the MCO can hopefully resolve it before payments stop.

6. Just Say No to Broad Audit Provisions

In our experience, MCOs occasionally include very onerous language into standard audit rights provisions. Most of the time, these rights are intended to enable the MCO to inspect claims and the grounds for those claims (which is reasonable). On the other hand, they should in no event give the MCO the right to enter your premises and inspect all of your books and records. We have seen such language in proposed agreements before, and it should absolutely be stricken. Dig your heels in on this one. Allowing MCOs that kind of unfettered access to your practice’s records not only jeopardizes the group’s proprietary rights, but it could also subject your practice to potential HIPAA violations.

7. Gray is not Good in Contracts

Suggestion no. 7 is really more general when compared to those we’ve covered thus far. When reading the proposed agreement, be sure to highlight any obligations imposed upon you that seem vague. One example we have seen routinely reads: “the Provider shall provide the Services in the most cost-effective manner”. Any idea what “cost-effective” means? We don’t either. If you’re like us, then delete the language. If the MCO thinks this provision is important and should stay in, then have them draft more specific language that everyone can understand. The idea here is that the purpose of the agreement is to clarify the obligations of the parties. Ambiguous language like “cost-effective” has the opposite effect, so make sure it stays out of your contract.

8. Do Your Research

While you may not have extensive experience with managed care contract language, a good document to keep as a reference is ACEP’s Model Emergency Physician Services Agreement with Managed Care Organization, which can be accessed by ACEP members on the www.acep.org website. Not surprisingly, the document is very one-sided in favor of ER docs. Nevertheless, consulting this document for substitute language and/or when trying to understand what other rights you might want to request should be very helpful.