

MANAGED CARE CONTRACT ISSUES

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1. **Silent PPOs**

A silent PPO arises when a contracting entity negotiates discounts with a Provider and then sells access to discounts to other, non-related parties after the Provider renders services to individuals covered by the non-related parties' insurance policies.

Example:

The following example demonstrates the mechanics of a silent PPO. A patient covered by an indemnity contract that allows access to any Provider receives treatment at Provider A. Provider A sends a bill in the amount of \$10,000 to the patient's indemnity insurer. There is no contract between the indemnity insurer and the Provider. The insurer then contacts a PPO, third-party administrator, or discount broker that has access to a list of contracting organizations with discounted arrangements with Provider A. The insurer remits a discounted payment to Provider A and references the specific PPO discount on its explanation of benefits (in this example, the discount is assumed to be 30 percent). Provider A receives a payment of \$7,000 (the \$10,000 billed for the patient less the 30 percent PPO discount), \$2,000 of which is paid by the patient as a coinsurance payment, and \$5,000 of which the insurer pays. The insurer pays an access fee to the PPO, ordinarily a percentage of the savings. An access fee of 40 percent would result in a payment of \$1,200 to the PPO and an \$1,800 cash savings to the insurer. This silent PPO arrangement costs the Provider \$3,000.

Solution:

- a. Try to include language in the PPO agreement requiring all parties who have access to the discounts to have a contract with the PPO
- b. Have PPO guarantee that its logo will be present on the patient's insurance card
- c. Have PPO require that all of its clients use its network exclusively in a geographic area
- d. Carefully define who the Payor is
- e. Specify the required component of the agreement between the PPO and Payor clients
- f. Limit the network size and build in financial penalties for increasing network size
- g. Attach Payor client list to the contract and assure that an addition will not be effective unless and until the Provider consents in writing
- h. Require payment rate confidentiality
- i. Prohibit any assignments of the agreement (Silent PPO arrangements may be considered partial assignments)

2. **Medical Record Issues**

Under South Carolina law, a patient has the right to confidentiality for the information contained in his or her medical records. Providers must protect the confidentiality of their patients' records. A patient's medical record is confidential and providers may be liable for breach of confidentiality if they divulge such confidential information related to a patient without the patient's consent or when required by law. This would include valid and proper subpoenas and court orders.

3. Amendment Language

One of the key problem areas in managed care contracting involves amendment to the agreements. Providers should be diligent in restricting the managed care organization's ability to unilaterally amend the contract. If possible, the provider should negotiate an amendment provision which requires the consent of either party prior to any amendment. At a minimum, the provider should be entitled to advance notice of the effective date of amendment. This should be monitored not only for the actual terms of the agreement but also for terms of program attachments or policies and procedures which deal with the administration of the managed care agreement.

Problem:

Oftentimes a Provider agreement will state that the Payor has the right to amend the contract with the Provider without prior written notice. Sometimes a slightly different variation of this type of provision may allow one party (usually the Payor) to propose amendments to the agreement to the other, and if the proposed amendment is not objected to within a certain number of days, the amendment becomes part of the contract. Providers must be wary of these types of provisions and should make timely objections or reserve the right to veto any amendment.

Solution:

Providers should read the Amendment section carefully and reject any language which gives the Payor unilateral amendment rights. If the agreement requires the Payor to provide notice of amendment and states unless the Provider objects within a certain time period (usually 30 days or less) then the Providers should monitor the Payor's conduct carefully and immediately object (in writing) to any proposed amendment which they do not want. Failure to do this could provide the Payor with a de facto unilateral amendment right.

4. Dispute Resolution Process

Many managed care contracts contain dispute resolution clauses. Dispute resolution clauses deal with how disputes related to the agreement will be handled by the parties. A dispute resolution process may include the following:

1. Mediation - This is an informal process where an independent third party will try to bring the parties together in agreement before the initiation of arbitration or litigation;

2. Arbitration - This is a more formal and often binding process in which both sides present their respective position to an independent arbitrator who will decide the outcome of the dispute; and
3. Litigation in court - This is a traditional bench trial in front of a judge or a jury trial in front of a jury.

5. Utilization Management and Quality Assurance Programs and Compliance

One of the key problems in the areas of utilization management and quality assurance is that the managed care organizations will subject providers to utilization management policies and procedures which are inconsistently and unfairly administered. In some cases providers are not even provided copies of these policies. Prior to executing any managed care agreement, providers must review each utilization management or quality assurance policy carefully and determine whether the payor had the right to amend this policy unilaterally or whether the policies are unfair. If the payor does retain a unilateral amendment right then the utilization management requirements can be a “moving target” for the provider which can give the payor more of an opportunity to wrongfully deny providers claims. In addition, providers should negotiate appeals rights for utilization management decisions in order to protect the business arrangement negotiated and arranged for by the providers when the contract is executed.

6. Obligations After the Termination of a Managed Care Agreement

A providers should think in advance about its obligations under the agreement once the contract has been terminated. Oftentimes payors will attempt to obligate a provider to continue to see patients for a certain period of time at a discounted rate. Since the provider will likely continue to see the patient as a matter of continuity of care, the provider should negotiate higher rates or lower discounts once the notice of termination has been provided.

7. Co-pay and Deductible Collections

Providers may bill enrollees and HMO only for previously specified payments such as co-payments, deductibles, or for non-covered services. Under these circumstances, the provider may not bill the patient if the HMO fails to pay its share of the bill. In South Carolina, this “hold harmless” law only applies to HMO agreements and other managed care organizations are not required to include this type of “Hold Harmless” language in their non-HMO managed care contracts.

South Carolina Law

S.C. Code Ann. 38-33-130

Each health maintenance organization shall require every Provider who participates in the health maintenance organization and furnishes health care services to the health maintenance organization’s Enrollees to execute an agreement not to bill the Enrollee or otherwise hold the Enrollee financially responsible for services rendered. The Provider’s agreement must be given on

forms prescribed or approved by the director (of the Department of Insurance) or his designee, shall extend to all services furnished to the Enrollee during the time he was enrolled in the health maintenance organization, and shall apply even where the Provider has not been paid by the health maintenance organization.

Solution:

The use of the hold harmless provisions usually comes into play for the difference between what the Providers charge and what the health maintenance organization actually pays for a procedure. It is not designed to prevent Providers from seeking co-payments, deductibles, and payment for non-covered services from Enrollees. This type of provision is designed to protect Enrollees from paying more for their health care than bargained for and, in the case of bankruptcy of a health maintenance organization, keeps the patient from being held responsible.

8. Billing and Claims Issues

In order to protect providers' right to reimbursement, providers should attempt to negotiate "clean claim or uncontested claim" language into the contract. Under this concept, once the provider has issued a clean or uncontested claim, then the payor would have a certain period of time in which to pay that claim. Often times, payors use ambiguous definitions of clean claims as a means of not paying claims. Provider should attempt to negotiate as narrow a language as possible to cover what its obligations are to meet the clean claim.

In addition to negotiating clean claim language, providers should also consider negotiating penalties for the payors failure to pay such clean claims within a timely manner.