Issue Brief #9:

An Evaluation of Agreements Between Managed Care Organizations and Community-Based Mental Illness and Addiction Disorder Treatment and Prevention Providers[1] [‡]

Sara Rosenbaum, J.D.
Joel Teitelbaum, J.D., LL.M.
D. Richard Mauery, M.P.H.

The George Washington University Medical Center
School of Public Health and Health Services
Center for Health Services Research and Policy

Marcie Zakheim, J.D.
Michael Golde, J.D., M.P.H.
Feldesman, Tucker, Leifer, Fidell and Bank

March, 2000

---

[1] The Department of Health and Human Services has reviewed and approved policy-related information within this document, but has not verified the accuracy of data or analysis presented. The opinions expressed herein are the views of the authors and do not necessarily reflect the official position of the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Care Financing Administration (HCFA), or the U.S. Department of Health and Human Services.

[‡] We would like to acknowledge the following individuals for their assistance in the preparation of this Issue Brief: Peter Shin of the Center for Health Services Research and Policy, who developed the database system used both for this brief as well as our other managed care contract studies; Barbie Robinson, Bill Burgess, Leilani DeCourcy, and Annie Khalid, who as students at the George Washington University School of Law, provided ongoing research support throughout the contract analysis phase and in the preparation of this brief; and as always, we wish to thank Dr. Eric Goplerud, Rita Vandivort, and Stephanie Dant-Wright for their ongoing guidance and support for both this and all of our projects with the Substance Abuse and Mental Health Services Administration.

Table of Contents

Executive Summary 1

Introduction 4

Research Methods 6

Findings 6

1. Services, Treatment Duties, and Treatment Decision-making *6*

Classes of Services 7

Description of Covered Services 8

Exclusionary Provisions 9

Exceptions to Uncovered Services 9

Prior Authorization of Covered Services 9

Treatment Decision-making 10

Emergency Coverage Limitations 10

2. Provider Access to Patients, Member Access to Providers, and the Provider/Patient Relationship *11*

The Duty to Treat Patients and Patient Referrals 11

Assurances of Patient Referrals 12

Providers' Right to Accept or Continue Treating Patients 12

Treatment Time Lines 13

Gag and Anti-Gag Clauses 13

3. Referrals to, and Relationships with, Other Providers *13*

Referral for Contract and Other Services 13

4. Enrollee Encounter Data and Eligibility Verifications *14*

Encounter Data 14

Eligibility Verification 14

5. Quality Assurance *15*

Structure of and Participation in Quality Assurance Systems 15

6. Compensation *15*

Capitation and Case Rate Payment Arrangements 15

Fee-for-Service Agreements 17

Incentive payments 17

7. Term and Termination *17*

Contract Term and Modification Rights 17

Termination of Contracts 17

Notice Periods 18

8. Post-Termination Treatment Obligations *18*

Post-Termination Obligations 18

9. Nature of the Relationship Between Contracting Parties *19*

Anti-Delegation Clauses 19

Exclusivity and Non-Exclusivity of Contractual Relationships 19

Resolution of Disputes 19

Summary of Contract Reviews *20*

Implications and Conclusions 20

Implications *20*

Conclusions *22*

Appendix: Examples of Provider Contract Language 24

Executive Summary

This Issue Brief, prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA), examines contracts between managed care organizations (MCOs) and community-based providers of mental illness and addiction disorder treatment and prevention services (MI/AD providers). Building upon initial research published in 1997,[2] this brief explores in depth one of the most hidden aspects of managed care: the relationship between the managed care organizations and health care providers.

The research upon which this brief is based was conducted between the fall of 1998 and the summer of 1999. Because of the competitive nature of managed care, most MCOs closely guard the nature and structure of their provider agreements. The contracts that form the database for this research have been blinded with respect to the MI/AD provider and MCO that are named in the documents, as well as the state in which the contract was entered into. We do not report our findings by state, name of health care provider, or name of plan, and the contract language quoted throughout this brief is similarly non-identifiable.

We contacted a total of 505 separate providers in all 50 states over a five-month period and received 112 separate documents (e.g., contracts, provider manuals, letters of agreement) from providers in 17 states (most providers furnished us with multiple contracts). After eliminating a handful of contracts from the database, 107 contracts remained.

At their most fundamental level, contracts serve to memorialize the relationship between the contracting parties by codifying in a written form the service provision and performance requirement expectations of both parties. We have found that these expectations vary widely across contracts, and in the case of MI/AD services often apply to a relatively narrow range of services that may not include integral services considered by experts to be necessary for comprehensive care. The MCOs retain extensive control over treatment decision-making and resource allocation decisions, and in cases where service duties are vaguely or ambiguously defined may expose the providers to unexpected residual liabilities. Treatment coverage decisions hinge on the interpretation of the contractual definitions of "medical necessity" and "emergency" – the absence or vagueness of such definitions in many contracts may result in significant financial risk for providers, especially those that receive capitated reimbursements.

There is a notable paucity of data reporting and performance measurement requirements in the agreements. This is especially significant in light of the growing use of capitation and case rate payment arrangements which are predicated on having reliable and timely performance information for effective care, quality, and cost management.

Providers are often exposed to extreme financial risk in many cases for failing to initiate enrollee eligibility verifications prior to providing treatment. The contracts are largely "at will" documents that permit termination and/or modification by either party under certain notice periods, however there is a trend towards the MCOs having more unilateral powers in this regard

[2] Rosenbaum S, Silver K, and Wehr E. *An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies*. Produced for the Substance Abuse and Mental Health Services Administration. August 1997.

than providers do. Providers may also experience significant unreimbursed costs when the contracts specify post-termination treatment obligations without clear assurances of payment by the MCOs.

The findings from this analysis suggest that despite efforts to regulate the industry at the state and federal levels, managed care remains essentially the same product: a corporate structure in which a controlling entity builds a "product" (in this case, some type of prepaid health care arrangement) that contains certain features that are integral to the product that is sold.

From the MCOs' point of view, they believe it is essential that their contracts with their suppliers (in this case, their medical care providers) embody certain basic features as detailed below:

Features Sought by MCOs in Provider Contracts:

- A duty imposed on providers to provide services to the MCO's members, from the time that the MCO assigns its members to, or permits members to obtain services from, the providers, until such time as the members are no longer members of the MCO;

- Acquiescence by providers with the MCO's participation and payment terms;

- A relatively tenuous connection between providers and the MCO that can be terminated by the MCO at any time and without cause;

- An ability to modify at any time the terms of provider participation and payment, as determined by the MCO to be necessary to its own ability to serve its members;

- An ability to provide a relatively standardized product that operates in accordance with centralized controls and incentives designed to achieve relatively reliable and quantifiable results;

- Close oversight by the MCO over providers in terms of treatment decision-making, often with services that often are ambiguously described;

- Significant sharing with providers in the substantial and frequently unforeseen substantial financial risks to which the MCO itself is exposed;

- Limitations on the role providers may play in decisions about how to allocate the resources available to the MCO; and

- A willingness on the part of providers to be exposed to legal liability for the consequences of the care that is furnished, even in situations in which the provider did not make the resource allocation decision in question that allegedly contributed to an injury.

Our initial study of managed care provider network agreements in 1996 revealed contracts that were built to favor the needs and demands of the managed care industry itself. The agreements we examined were constructed to shift significant amounts of financial risk onto

individual health professionals, to affect their resource consumption choices through the use of powerful financial incentives such as capitation payments and withhold arrangements, and to manage and restrain providers' discretionary choices over the use of health plan benefits and services. Because agreement to these contracts was a precondition to access to patients and insurance revenues, it became evident that health professionals who wished to continue to run a practice comprised chiefly of insurance payments (as most practices are) had no choice but to sign. This sense of inevitability regarding the terms of participation was confirmed in our interviews with individual health care providers who felt that they had essentially no bargaining leverage.

Despite the passage of time, this study yields essentially the same findings. Part of this policy stasis is attributable to the inherent nature of the managed care industry. In order to run an industry that entails the acceptance of financial risk and the control over resource utilization, the managed care entities must ensure that employees and subcontractors play by the same rules. Managed care contracts cannot change significantly unless the relative balance of power between MCOs and providers also changes in fundamental ways.

However, the lack of change in the nature of these contracts should not be interpreted as passive acceptance of their terms. Over the past several years, a series of major challenges to these arrangements have been mounted in various forums, although nearly all have lost. Thus, these contracts must be understood as products of deliberate policy choices made by courts and legislative bodies alike in the face of demands for change by health care providers. In the intervening time period between our first and second studies, a series of legal challenges against these agreements have been mounted. Based on a range of legal theories, these lawsuits have sought to have the agreements voided either completely or in significant part, as void for public policy, an unlawful restraint on trade, or for other reasons. These challenges to the enforceability of provider network agreements have failed for the most part,[3] as have efforts at the national and state level to legislatively outlaw the use of contracts-at-will that create substantial financial risk and control treatment decision making. These losses in both courts and in the legislative arena underscore how resistant judges and policymakers may be to the notion of interfering with the workings of the market, particularly given the lack of data on the consequences of such agreements for patient health.

There may come a time when the industry as a whole concludes that regardless of the price concessions from suppliers, the extent to which financial risk can be downstreamed, and the controls over resource consumption that can be maintained, the business of managed care simply is not lucrative enough to justify a major investment of capital. Until the basic structure for controlling the allocation of health resources among insured Americans goes through another round of fundamental change, however, it is probably safe to assume that the contracts between managed care organizations and their provider networks may be modestly altered through negotiation, but that at the same time, their fundamental nature will survive.

[3] Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System*. Foundation Press, NY NY 1997; 1999-2000 Supplement.

Introduction

This Issue Brief, prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA), examines contracts between managed care organizations (MCOs) and community-based providers of mental illness and addiction disorder treatment and prevention services (MI/AD providers). Building upon initial research published in 1997,[4] this brief explores in depth one of the most hidden aspects of managed care: the relationship between the managed care organizations and health care providers.

Whether they are large national corporations with millions of members or small indigenous companies offering a limited array of services and products, managed care organizations are extremely complex legal creatures. They have undertaken to provide a contractual array of medical and health care to large numbers of enrollees have incurred extensive contractual duties toward their group sponsors. MCOs carry significant financial risk and depend for corporate survival on their ability to control not only the allocation of resources but also the conduct of their employees and subcontractors.

While new managed care "makes and models" have emerged since 1997, (most notably the Medicare+Choice organization), the essential structure of managed care remains the same.

> *For purposes of this brief, we define managed care as any medical care system in which a corporation contracts to both sell medical care and deliver the services it sells through a network of providers and institutions that are either employed by the entity or selected to contract with it, and whose patient care activities are subject to organizational controls.*

Over the past three years, managed care – and in particular, its effects on the accessibility and quality of care and on the nature of the provider/patient relationship – has received enormous attention. The terms and conditions embodied in the contracts between MCOs and their providers, to the extent that they define what and how services are provided to patients as part of their benefit packages, have significant implications for patients' access to care. The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry issued a Patient's Bill of Rights that recommends new standards for many aspects of managed care.[5] Numerous measures were introduced in the 106th Congress to implement some or most aspects of the Bill of Rights.[6] Medicare and Medicaid have been significantly revised to establish new standards for the purchase of managed care plans and new patient safeguards. National managed

---

[4] Rosenbaum S, Silver K, and Wehr E. *An Evaluation of Contracts Between Managed Care Organizations and Community Mental Health and Substance Abuse Treatment and Prevention Agencies*. op.cit.

[5] Consumer Bill of Rights and Responsibilities: Report to the President of the United States. November 1997. Available at http://www.hcqualitycommission.gov/final/append_a.html. Accessed March 1, 2000.

[6] For a comparison of H.R. 2990 and S. 1344 (in conference committee at the time of this writing), see Phyllis Borzi and Sara Rosenbaum, "Pending Patient Protection Legislation: A Comparative Analysis of Key Provisions of the House and Senate Versions of H.R. 2990," Prepared for the Henry J. Kaiser Family Foundation, Center for Health Services Research and Policy, The School of Public Health and Health Services, The George Washington University Medical Center. March 2000. Available at: http://www.kff.org/content/2000/20000310a/. Accessed March 17, 2000.

care accreditation organizations have developed new patient protection standards that apply to all managed care entities that seek accreditation. As of mid-year 1999, 48 states have enacted or introduced legislation regarding some form of managed care protection (Wyoming and Kentucky are the two exceptions).[7]

Many managed care organizations have voluntarily chosen to adopt certain patient safeguards in the areas of access, disclosure, and external reviews of certain types of treatment decisions. For example, Magellan Behavioral Health's National Provider Handbook includes a section on members' rights and responsibilities, covering such areas as nondiscriminatory treatment, confidentiality, access to treatment options, information on Magellan's services and role in the treatment process, rights to participation in treatment decisions, and access to complaint, grievance, and appeals processes.[8]

In their roles as professional associations for MCOs, both the American Association of Health Plans (AAHP) and the American Behavioral Healthcare Association (AMBHA) have formally adopted codes of conduct that apply to their member organizations. These codes, like the Magellan example above, cover a variety of policies related to enrollee rights and responsibilities. As of February 1997, AAHP requires member health plans to uphold these "patient-centered policies" as a condition of their membership in AAHP.[9] AMBHA has both a code of conduct for its member MCOs, as well as a "Bill of Rights for Consumers Accessing Behavioral Health Services."[10] Both AAHP and AMBHA make these documents available on their websites.

Health care providers in recent years have challenged the level of control over access to patients and treatment decision-making that the managed care contracts engender. At least one of the early managed care reform measures considered in Congress would have outlawed the "at will" provider agreement which allows a managed care company to terminate an agreement with a provider at any time and without notice.[11] Legislatures in a number of states have enacted legislation that would prohibit contract terminations without cause. Several courts have declared the use of "at will" termination clauses to violate basic notions of due process.[12] And at least one highly influential federal appeals court has declared the use by employers of provider-owned managed care organizations that contract with their owner-providers to furnish health care on an incentive basis a violation of ERISA's fiduciary requirements.[13] Oral arguments before the U.S. Supreme Court were presented in February 2000, with a decision likely to be rendered by summer 2000.[14]

---

[7] *1999 Health Care Activities: A State by State Mid-Year Review*. Prepared by The Health Policy Tracking Service, National Conference of State Legislatures. April 1999.
[8] Magellan Health Care, National Provider Handbook. "The Quality Partnership: Members' Rights and Responsibilities." Available at http://www.magellanhealth.com. Accessed March 21, 2000.
[9] American Association of Health Plans. Code of Conduct. Available at http://www.aahp.org. Accessed March 21, 2000.
[10] American Managed Behavioral Healthcare Association. Available at http://www.ambha.org. Accessed March 21, 2000.
[11] H.R. 2400, 104th Congress.
[12] *See, e.g., Harper v Healthsource, New Hampshire, Inc*. 674 A.2d 962 (N.H. 1996).
[13] *Herdrich v Pegram*, 154 F.3d 362 (7th Cir. 1998), pet. for rehearing en banc den., 170 F.3d 683 (7th Cir. 1999).
[14] Certiorari was granted in September 1999, 144 L. Ed. 2d 841.

While contracts for the provision of MI/AD services form the database for this analysis, our work on other types of managed care contracts[15] leads us to conclude that these findings can be generalized to managed care provider agreements as a group and across service classes.

Research Methods

The research upon which this brief is based was conducted between the fall of 1998 and the summer of 1999. Because of the competitive nature of managed care, most MCOs closely guard the nature and structure of their provider agreements. The contracts that form the database for this research have been blinded with respect to the MI/AD provider and MCO that are named in the documents, as well as the state in which the contract was entered into. We do not report our findings by state, name of health care provider, or name of plan, and the contract language quoted throughout this brief is similarly non-identifiable.

We contacted a total of 505 separate providers in all 50 states over a five-month period and received 112 separate documents (e.g., contracts, provider manuals, letters of agreement) from providers in 17 states (most providers furnished us with multiple contracts). After eliminating a handful of contracts from the database, 107 contracts remained.

Several lawyers with extensive experience in contract analysis reviewed the documents in accordance with a protocol developed to ensure uniformity in interpretation. The instrument was designed to permit answers of, for example, "yes", "no", "unclear", and "not addressed." Reviewing attorneys commented for later resolution and consultation on sections that presented ambiguities. Once the attorneys reviewed each contract and completed the data collection instrument, the data were entered and analytical frequency tables were prepared.

The majority of MCOs (78%) represented in the contracts are companies that sell comprehensive, integrated service products. In some cases, the product may be insured (that is, the MCO may directly insure what it sells); in others, the MCO may be the administrator for a self-insured employee benefit plan. More limited MCOs offering provider network products are the contractors in 21% of the documents. The remaining organizations are Employee Assistance Programs (EAPs), state Medicaid agencies, and MCOs selling workers' compensation products. In five of the documents, the nature of the contracting organization was unclear.

Findings

1. Services, Treatment Duties, and Treatment Decision-making

The contracts reviewed showed that MCOs purchase a relatively narrow range of services from providers, omitting many of the types of services identified by experts as integral to the proper management and prevention of mental illness and addiction disorders. This limitation is largely typical of commercial sector behavioral health plans. In some cases, the contracts describe network provider service duties in ambiguous terms (particularly in the case of

[15] Other projects at the Center include the evaluation of primary care case management contracts as well as contracts for hospital, nursing home, and rehabilitation services.

emergency care), a practice that can lead to significant and potentially unanticipated financial risk in the case of capitated providers. As in 1996, the contracts continue to demonstrate strong MCO control over treatment decision-making and the allocation of plan resources to individual patients. Numerous contracts reflect a basic inconsistency with the prudent layperson emergency coverage standard that applies to both Medicare and Medicaid-sponsored enrollees, members of federal employee health benefit plans, and plans subject to state insurance regulation in states that have passed prudent layperson standards of emergency care coverage.

Classes of Services

As would be expected in a study of mental illness and addiction disorder services, the overwhelming majority of contracts limit the classes of covered services to mental health and/or substance abuse services (84% and 57% respectively). However, the contracts show a decline from 68% to 57% since 1996 in the proportion of contracts that identify substance abuse services as a specific class of service for which the provider is obligated. Since the solicitation of these contracts was aimed at the same group of providers that had participated in 1996 and was even expanded to include additional substance abuse providers, it is doubtful that this change in the scope of the service obligations can be attributed to a change in provider mix. Whether this change signals a declining level of coverage of substance abuse services in the prime contracts themselves cannot be known from this study.

Only one contract in 1999 contained language specific to the treatment of patients with co-occurring MI/AD conditions. The importance of whether treatment of co-occurring conditions is named as a specific service obligation depends on whether in treating persons with co-occurring conditions, providers would employ specialized treatment skills that differ from those applied when treating each condition separately. To the extent that the management of co-occurring conditions does in fact require specialized MI/AD treatment, then the low number of contracts containing the service obligation compared to the prevalence of the condition is notable.

Consistent with 1996, in 15% of the contracts, reviewers were unable to classify the service obligations in any manner, since no description was given. For any provider, vagueness in the identification of service obligations is a problem, since it means that a provider does not know what is expected and may have full discretion to furnish or withhold entire classes of covered care from a patient on the ground that the care falls outside the provider's obligation.

Since the use of capitation agreements appears to be increasing, as discussed below, the absence of clear service terms can create extreme -- and unanticipated -- financial risk on the part of health care providers. If an MCO takes the position that the capitation agreement covers all "medical" care or simply all care in the case of contracts with no service description, then a provider can find itself faced with a level of financial exposure that goes well beyond the provider's assumptions at the time that the contract was entered into.

Support services, e.g., translation and case management, which are often referred to as "wraparound" services in the context of Medicaid, are not addressed at all in the contracts. The

absence of reference to services that are frequently specified in Medicaid master agreements[16] may be because the enrollees who are sponsored under the provider sub-contracts reviewed in this study are privately insured. However, in light of the fact that 14 of the 17 providers (82%) from whom the contracts were collected are community based MI/AD providers located in states that contract for managed Medicaid behavioral health services,[17] the absence of any mention of services covered in most Medicaid master agreements is notable. Even if the provider is not responsible for furnishing these services under the sub-contract, the sub-contract in theory might at least specify the MCO's obligation to furnish the service.

Description of Covered Services

As in 1996, the most striking aspect of the contracts is the very limited range of care that MCOs appear to purchase from community providers, though this limited range of care is typical for commercial plans. Most of the contracts omit the more intensive services that were identified by our experts as integral to the proper management and prevention of serious mental illness and addiction disorders. While contracts appear to cover diagnosis and medical treatment under one classification or another, the terms are not defined. Many services specifically identified as essential to care are not discussed. Among the 107 contracts:

- 32 contracts (30%) (29 fee-for-service, three capitated) cover evaluation, treatment planning, and service coordination;
- 8 contracts (7.5%) (6 fee-for-service and two capitated) cover crisis hotline services;
- one contract (1%) (fee-for-service) covers relapse prevention;
- 28 contracts (26%) (26 fee-for-service, 2 capitation) cover medication management; and
- two contracts (1.9%) (fee for service) cover translation services.

In some cases, the MCO may furnish these services directly or through other providers. However, the contracts do not indicate this, nor do they direct the providers how to secure these uncovered services for their patients. It is possible that some of these services are considered by MCOs to be part and parcel of "diagnosis" and "physician" or "outpatient" treatment. To the extent that the service is not reflected in the compensation scheme, then there would be no reason to assume that the company anticipates that it will purchase the service.

---

[16] Rosenbaum, S *et al*. Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 3rd Edition. Center for Health Services Research and Policy, School of Public Health and Health Services, The George Washington University Medical Center. June 1999. This analysis indicated that 19 Medicaid master agreements specify transportation services, 37 specify translation services, and 46 specify case management services. Even if the provider is not responsible for furnishing these services, the contract in theory would specify the MCO's obligation.
[17] Of the 17 states represented in the provider contract study, 2 are not represented in the Negotiating the New Health System database, and 1 state carves out MI/AD services into the fee-for-service sector.

Exclusionary Provisions

Of equal importance are the service exclusions that are found in some of the contracts. For example, several agreements specify that "maintenance care" as defined in the contract is excluded from covered services. This likely reflects the emphasis on acute care services as found in most commercial sector health plans. Services to maintain proper health and functioning in the face of a chronic or recurring condition are considered integral to proper practice by professionals. The evidence from the contracts suggest that at least some managed care organizations expressly prohibit providers from seeking reimbursement for the provision of such services. See example 1.1 in the Appendix for contract language.

Exceptions to Uncovered Services

A contract may classify one or more services as generally uncovered but may permit a provider to seek an exception for coverage in certain cases. We were able to find only one contract (Example 1.2, Appendix) that made such a provision allowing the provider to request additional MI/AD services once maximum benefit limits have been reached.

Appendix example 1.3 is a contract that imposes upon providers the duty to provide substance abuse treatment "Aftercare Services" to covered members solely at the expense of the providers. Such services are not included in the benefit package or fee schedule.

Prior Authorization of Covered Services

Prior authorization is a hallmark of utilization management in both managed care and traditional insurance arrangements. There was a decline between 1996 and 1999 from 82% to 57% in contracts with explicit prior authorization requirements, possibly indicating greater reliance on capitation and incentive arrangements to control the allocation of health care resources and treatment decision-making. What is striking about the 1999 contracts is that in the remaining 43% of them, prior authorization requirements were either unclear or not addressed. It is possible that these provisions might appear in provider manuals (which were not examined in this study), or that the MCO simply uses no prior authorization requirements.

The percentage of contracts requiring providers to obtain prior authorization from the enrollee's primary care provider decreased slightly from 10% in 1996 to 7% in 1999, again with a substantial increase in the percentage of contracts that do not address this requirement.

What is most striking perhaps is the relatively large proportion of contracts (42%) that require providers to obtain prior authorization from the MCO in emergency coverage cases. This is further evidenced by the fact that the percentage of contracts which expressly exempt emergency treatment from prior authorization requirements declined significantly in 1999, down from 61% to 42% of contracts that require prior authorization. As previously mentioned, such emergency treatment prior authorization exemptions may appear in provider manuals, which were not included in this study.

Even in the case of contracts that exempt emergency care from prior authorization, they frequently specify that providers must submit emergency treatment authorizations to the MCO within 12 to 48 hours for retrospective MCO review.

Examples 1.4 through 1.6 (Appendix) illustrate emergency care and other prior authorization requirements. Some are extraordinarily sweeping and prohibit the provision of virtually any care without permission (which as discussed below may be a lengthy process). The excerpts also illustrate the potential consequences to the provider for failing to abide by them, e.g., potential denial of payment for services rendered.

Treatment Decision-making

The percentage of contracts that contain an express coverage limitation related to the medical necessity of care decreased to 57% in 1999, down from 72% in 1996. The greater use of capitation agreements may account for this at least in part. Among the contracts with medical necessity provisions, the majority (41 out of 61 contracts) contains language that commits the determination to the discretion of the medical director. Only four contracts expressly specify that the provider's judgment will control.

Consistent with the 1996 findings, no contracts separately define a medical necessity standard for children, and only one contract defined medical necessity standards in relation to currently recognized placement criteria.

The medical necessity and emergency definitions in the contracts demonstrate a broad array of approaches for defining medical necessity. In no case could we find a definition that treats as medically necessary an intervention that is furnished in the absence of a diagnosis of an illness or condition (i.e., a purely preventive intervention). To the extent that truly preventive interventions are covered, they would presumably be specifically listed in the contract, much in the way that well child care or immunizations are specifically listed as a non-diagnostic-related covered service or benefit.

The fact that the medical necessity definitions do not contain a preventive clause makes the low coverage of preventive services even more important.

Emergency Coverage Limitations

Despite the advances in federal and state law in the area of emergency care, the contracts show a surprising level of inconsistency with recent federal and state reforms.

The percentage of contracts that define emergencies declined from 45% in 1996 to 33% in 1999. Of the 35 contracts in 1999 that contain emergency definitions, 40% and 57% of contracts include definitions of substance abuse-related and mental health-related emergencies,

respectively. Only 6% of the 1999 contracts referred to a "prudent layperson" standard in their emergency definitions.

Examples 1.7 and 1.8 (Appendix) provide illustrations of mental illness or addiction disorders-related emergency definitions.

Nearly 50% of all contracts that require prior authorization of services do not expressly exempt emergency conditions from prior authorization procedures. Furthermore, only 8% of the contracts exempt emergency services from requirements that an in-network provider furnish the service. This represents a decline from 32% in 1996 that contained such an express exemption.

It is important to note that members' coverage documents may in fact specify that they may obtain emergency care in accordance with a prudent layperson standard from any provider and without prior authorization. However, this review of the provider contracts suggests that the terms in the contracts do not conform to current legal requirements. It is true that the primary goal of the federal and state emergency care laws that have been enacted is to improve coverage and the disclosure of coverage to members. However, the failure on the part of MCOs to bring their provider subcontracts into line with these legal changes could lead to serious problems for the patient, the provider, and the health care organization. For example, if a provider, operating under the assumption that in medical emergencies prior authorization is required or that only certain facilities may be used, were to counsel a patient against seeking care pending permission from the plan, the patient (or his or her survivors) may have claims against both the provider and the MCO in the event that the delay leads to injury or death.[18]

2. Provider Access to Patients, Member Access to Providers, and the Provider/Patient Relationship

The contracts create a duty to accept and treat members who select, or are assigned to, the provider. In this respect, the contracts represent a major departure from common law, which specifies that with certain limited exceptions for hospitals operating emergency rooms, providers have no duty to treat individuals. Even in the case of capitated payment arrangements, almost no contract guarantees providers a minimum enrollment. In relatively narrowly described circumstances, providers may reject new patients or discontinue treating a patient in their practice. Isolated examples of clauses that could be construed as gag clauses continue to appear.

The Duty to Treat Patients and Patient Referrals

All of the contracts impose a duty upon the providers to treat MCO-referred patients, typically requiring that the quality and scope of such treatment not differentiate between such covered members and providers' patients who are not covered by the particular contract.

[18] The failure to provide services that as a matter of law are expressly covered in a contract would be a violation of federal law in the case of Medicare and Medicaid. It also would violate numerous state insurance, fraud, and tort laws. Virtually all versions of legislation pending in Congress to establish patient protections in managed care would make such a failure a violation of ERISA.

Many of the contracts contain language specifying that the intent of the agreements is not to infringe upon the provider/patient relationship. They state that the MCO has no control over the professional judgments and decisions of the providers, and that the MCO's role is limited to service coverage benefit determinations. Of particular interest is the contracts' attempt to distinguish the MCO's coverage determination activities from the quality of care the patient receives, as shown by the highlighted language Example 2.1 (Appendix).[19]

Assurances of Patient Referrals

With the exception of one capitation agreement (discussed in Section 6, below) and the eight Medicare contracts noted previously, none of the agreements assures any specific level of referrals or service utilization. This is especially significant for providers reimbursed on a capitation basis, where the size of the enrolled population becomes critical.

Providers' Right to Accept or Continue Treating Patients

In regards to providers' ability to either accept or refuse new patients or to refuse to continue treatment to established patients, none of the contracts permit treatment termination on the bases of inability to maintain a professional relationship, enrollee's loss of insurance coverage, or enrollee's disruptive or abusive behavior. In some contracts, providers do have the ability to refuse acceptance or discontinue treatment of patients when 1) enrollees fail to pay required copayments, deductibles, coinsurance or other amounts; 2) continued treatment of the patient is deemed "unproductive" or "otherwise clinically inappropriate" by both the provider and the MCO; or 3) provider's practice load is full and he or she is not accepting new patients, regardless of payment source.

In Example 2.2, an at-risk contract, the provider is subject to penalties for failing to maintain an MCO-defined level of patient service utilization. MCO members who do not receive services for 60 consecutive days are required to be disenrolled from the plan, and a provider who demonstrates a pattern of under-utilization is assessed a penalty in the form of reduced capitation payments in subsequent months. This addresses concerns in risk-based systems that cost savings accrue due to members not presenting for potentially needed services that have already been paid for in a PMPM capitation payment or case rate payment.

[19] It is worth noting that such clauses essentially have no meaning from a legal liability point of view. Courts increasingly are finding managed care organizations both directly and vicariously liable under state law malpractice and negligence theories for damages incurred by patients as a result of substandard medical care. Courts also have been more willing to characterize certain types of conduct as related to the quality of treatment rather than a "mere" coverage determination. *See* Law and the American Health Care System, (Ch. 3 and 1999 Supplement) op cit.

Treatment Time Lines

Consistent with our 1996 findings, our 1999 review shows that the overwhelming majority of contracts (80% in the case of substance abuse and 76% in the case of mental health) do not establish timelines within which services for mental health and substance abuse-related disorders must be provided. This includes different stages of therapy or patient needs, e.g., emergency, routine, urgent, etc. Whereas in 1996, 16% of contracts did establish substance abuse timelines, that number decreased to 7% in 1999. A similar decrease can be seen in the case of mental health timelines, from 14% to 8% of all contracts. Of those contracts that do specify timelines (17 in 1999 and 8 in 1996), MCOs often measure provider compliance with these timelines in the process of quality assurance activities, as discussed below.

The length of timelines specified in the contracts ranges from "immediately" to "within 10 days" in cases of emergency. Timelines for "urgent cases" range from 24 to 72 hours. Similarly, for "non-emergency, non-urgent care." timelines range from 24 hours to 10 days. "Routine appointment" timelines range from 24 hours to within 5 business days. One contract specified "within 3 days" for post-hospitalization appointments. As in 1996, there is no consistent pattern across contracts.

Gag and Anti-Gag Clauses

Possibly due to the amount of attention that has been paid to gag clauses and their outlawing under Medicare and Medicaid,[20] as well as by the majority of states, only a few contracts contain clauses that could be construed as gag clauses. Examples 2.3 and 2.4 both represent typical non-disclosure clauses. However, nothing in the clauses as drafted exempts provider patient communications from the scope of the non-disclosure obligation.

At the same time, several contracts specifically recognize the recent effects of federal and state anti-gag clause legislation, such as those in Examples 2.5 and 2.6.

3. Referrals to, and Relationships with, Other Providers

In general, the contracts provide very limited provisions regarding the relationship that providers are expected to maintain with other providers who serve the patients.

Referral for Contract and Other Services

MCOs have established networks of contracted providers, including primary and specialty care physicians and hospitals and thus specify that as a general rule, referrals to other providers must occur within their network.

---

[20] Sections 1852(J)(3); 42 U.S.C. 1395W-22(J)(3), and 1932(B)(3)(A); 42 U.S.C. 1396U-2(B)(3)(A) of the Social Security Act.

The great majority of contracts do not contain such a referral limitation, presumably because these are contracts with referral providers of MI/AD services rather than with primary care providers. Several contracts address the level of discretion a provider has to arrange treatment in another site if necessary in the provider's judgment.

Twenty percent of the 1999 contracts require care coordination between the MI/AD providers and primary care providers. It is not possible to know from this study whether primary care providers have a duty to consult with the referral providers or furnish necessary information to aid in the referral.

As in 1996, with the exception of coordination arrangements with primary care providers, only a handful of contracts require coordination arrangements with criminal justice systems, child protective services, social service agencies, etc.

Examples 3.1 and 3.2 illustrate how the contracts address provider referrals and coordination arrangements with primary care providers and other providers.

4. Enrollee Encounter Data and Eligibility Verifications

The provision of data and access to data are hardly addressed in the contracts, despite the need for data in managed care and the cost of complying with data requirements. As is the case with other provisions that potentially require certain services from the MCO, the contracts obligate the MCOs to almost no services in exchange for the services furnished by the providers. With respect to the issue of eligibility verification, the contracts appear to place providers at extreme financial risk.

Encounter Data

Only a minority of contracts requires providers to submit enrollee encounter data to MCOs. This percentage has decreased form 16% in 1996 to 8% in 1999. Most contracts are either silent or unclear on this issue.

We expanded the 1999 study to include a new question regarding whether the contract provides for the submission of treatment outcome-related information to the MCO. Eight percent of the contracts require enrollee outcome data. Examples 4.1 and 4.2 illustrate requirements for submission of encounter and member outcomes data.

Eligibility Verification

The 1999 study findings are relatively consistent with 1996 with respect to the issue of eligibility verification. Approximately 30% of contracts require providers to contact the MCOs to verify a patient's eligibility to receive services prior to rendering them. However, only 17% of contracts stipulate 24-hour, 7-days-per-week availability of eligibility verification services, down from 27% in 1996.

In Example 4.3, providers assume the risk of the cost associated with treating individuals who in fact are not enrollees. This risk is unlimited and attaches regardless of whether the fault lies with the provider or the MCO. Furthermore, there is no retrospective cutoff point regarding an MCO's power to look back for erroneous enrollment data and recoup payments from providers.

5. Quality Assurance

With certain limited exceptions, the contracts do not address the role of providers in quality assurance systems. The percentage of contracts requiring providers to participate in MCOs' quality assurance systems decreased from 84% in 1996 to 67% in 1999.

Structure of and Participation in Quality Assurance Systems

The percentage of contracts requiring providers to participate in MCOs' quality assurance systems decreased from 84% in 1996 to 67% in 1999. As in 1996, no contracts require that individuals with substance abuse treatment experience, training, or credentials participate in the quality assurance system, and only one contract requires similar participation by a mental health professional.

Only 13% and 12% of contracts, respectively, require providers to make available to MCOs data related to quality assurance and enrollee utilization, and only 5% contain an explicit link between performance measures and duties.

Of those contracts that did address quality assurance, several provide notable specifications regarding quality assurance obligations. Other MCOs may have elaborate quality assurance systems that are revealed to providers once they are members of the network. This of course raises questions regarding the extent to which a provider is apprised of its contractual duties – or the cost of the duties – prior to agreeing to join a network. Examples 5.1 and 5.2 illustrate quality assurance and quality management standards that MCOs require of contracted providers.

6. Compensation

Our findings suggest a growing use of capitation and case rate payment arrangements, although fee-for-service reimbursement mechanisms predominate as found in 80% of the 1999 contracts.

Capitation and Case Rate Payment Arrangements

Contracts in the provider contracts database containing capitation and case rate payment arrangements were coded under the general category of "capitation." While these forms of reimbursement are different, they both involve the potential downstreaming of risk from the MCOs to the providers.

In the case of capitation, providers are typically paid a fixed per-member-per-month (PMPM) fee for all enrollees under their care, regardless of whether a particular enrollee accesses services during that month. Over a period of time, for instance one year, the provider is at risk for the costs of services rendered that exceed the 12 monthly capitation payments received.

Under case rate payment arrangements, by contrast, a provider receives a monthly payment for enrollees who have been diagnosed with specific conditions and are undergoing treatment. For instance, the MCO may pay the provider $1,200 monthly for the treatment of an enrollee diagnosed with an addiction disorder. This payment is intended to cover a comprehensive array of MCO-defined services. The provider is at risk for the cost of services which exceed the fixed payment or which represent services which the provider feels are medically necessary but are not included in the MCO's definition of covered services in the case payment arrangement.

Compared to 1996, the 1999 database shows considerable growth in the use of capitation and case rate payment arrangements. In 1999, 20% contracts provided either for capitation payments or case payments (i.e., payments on a per member per month basis rather than global payments for certain types of cases or fee-for-service payment in accordance with a procedure code).

Examples 6.1 through 6.5 show the variation in case payment arrangements. One contract appears to create a true capitation arrangement, although it is broadly described and not amenable to much analysis. The case rate payment arrangements appear to utilize a variety of incentives for promoting the provision of care within the case rate.

The case rate payment structures are notable for their variation. The provider named in Example 6.1 is the same as the provider in Example 6.2. Yet the case payment in the latter example anticipates twice the number of visits as under the former, although the rates are almost identical. It is not possible to tell whether Example 6.1 anticipates more complex or lengthy visits and more procedures and services per visit, which could explain the variation.

Examples 6.3 and 6.4 provide for capitation payments. Example 6.3 guarantees neither a minimum amount nor a minimum number of enrollees; Example 6.4 does. Note that the withhold in Example 6.4 places the provider at risk for pharmacy benefits.

Example 6.5 demonstrates the creation of a capitation arrangement. While the arrangement establishes risk corridors and defined payment rates, the provision also grants the MCO significant discretion to withhold portions of the capitation amount otherwise payable for a variety of reasons. The provision guarantees no minimum enrollment.

Fee-for-Service Agreements

As in 1996, the majority (70%) of contracts contains fee-for-service arrangements, although the percentage in 1996 was 98%, reflecting the increased use of capitated and case payment systems in 1999. Among the FFS contracts, only a very few contain provisions for either incentive or shared savings arrangements. Example 6.6 and 6.7 illustrate fee-for-service arrangements.

Incentive payments

Incentive plans (e.g., return of withholds or the ability to retain overages) appear to be a hallmark of the case rate and capitation agreements only. Incentive plans are not unusual in primary care fee-for-service contracts. We could find only one contract (Example 6.8) that appears to tie incentive arrangements to any degree to patient outcomes or the successful completion of certain forms of treatment. This agreement is extremely vague and allows the MCO to avoid the program entirely by never identifying bases for incentives.

7. Term and Termination

Contract Term and Modification Rights

As in 1996, the 1999 contracts are contracts of indefinite duration (i.e., evergreen) rather than documents for a fixed term. In addition, as in 1996, the MCO retains the right to unilaterally modify the terms of the agreement during the period of the contract.

Termination of Contracts

As in 1996, the contracts are overwhelmingly “at will” documents. That is, the contracts can be terminated upon notice and without cause. Both parties typically have a right to invoke a “no cause” termination. 82% of the 1999 contracts permit both the providers and the MCOs to terminate (with notice), although this percentage has declined from 92% in 1996. Compared to 1996, more contracts in 1999 are either unclear or do not address no-cause terminations. See Examples 7.1 and 7.2 for sample language regarding no-cause terminations.

Terminations with cause by providers are allowed in 60% of the 1999 contracts, with a corresponding 72% of contracts according such rights to MCOs. This represents a decline in cause-related termination clauses since 1996, when the right to terminate for cause stood at 82% of providers and 94% of MCOs.

Consistent with the findings above on no-cause terminations, more contracts in 1999 do not address or are unclear on terminations with cause.

Though not separately identified in 1996, an examination of termination with cause for specific circumstances reveals that the contracts define these circumstances for the MCOs much more frequently than they do for the providers.

Nearly 70% of the contracts define specific circumstances under which MCOs can terminate the contracts, as opposed to only 14% of contracts contain specific circumstances for provider termination. Examples 7.3 and 7.4 are examples of specific breach on the part of providers that MCOs can use to justify termination of the contracts.

Notice Periods

Termination notice periods refer to the length of time the contracts require the MCOs and the providers to give notice of contract termination, either for no cause or with cause. The majority of contracts specify 90 or more days notice for without-cause terminations, whereas 30 or fewer days notice are required for with-cause terminations. The percent of contracts not specifying timelines for with-cause terminations is higher than for without-cause terminations, leaving providers with no contractually fixed notice period in case of a cause-related termination. Examples 7.5 and 7.6 illustrate 30, 60 and 125 days notice periods.

8. Post-Termination Treatment Obligations

As in 1996, post-termination treatment obligations are common and create significant financial obligations on the part of providers to continue treatment, in some cases with no assurance of payment. This finding is especially important in light of the increase in the frequency of MCO bankruptcies and corporate reorganizations that result from mergers and acquisitions.

Post-Termination Obligations

Once a contract has terminated, whether at its agreed-upon expiration date or prematurely as a result of the invocation of a no-cause or with-cause termination clause, the contracts by and large provide for the continued treatment of the MCO enrollees until transfer to another provider. 62% of the contracts specified post-termination treatment obligations when either the MCO or the provider elects to terminate the contract, an increase from 46% in 1996. A smaller number of contracts (15%) provide post-termination treatment obligations if the MCO files for bankruptcy or becomes insolvent (up from 10% in 1996).

Consistent with the 1996 study, a majority of contracts require the MCO to continue paying the providers for post-termination treatment (58%). More than 40 percent, however, contain no provisions regarding payment.

Only 25% of contracts specify maximum timelines for the performance of post-termination treatment obligations. The contracts typically are open-ended ("as soon as practicable" until time as enrollee's care can be transferred). Some contain specific maximum

lengths of time, such as 130 days or even as long as 12 months. Examples 8.1 and 8.2 illustrate payment arrangements and provider obligations for post-termination treatment.

9. Nature of the Relationship Between Contracting Parties

In structuring their agreements, MCOs tend to favor non-exclusive contracts that maintain an independent status for network providers and that grant the MCO maximum flexibility over future business decisions related to the sale or disposal of the company.

Anti-Delegation Clauses

The issue of the ability of the MCOs and the providers to assign and/or delegate their rights and responsibilities to others becomes important in the event of a sale of an MCO to a successor organization with which a provider may or may not want to do business.

In two thirds of the contracts, the MCO retained the right to sell or assign its rights and interests to another. A slightly smaller proportion of the agreements allowed providers similar rights (55%). Where sale and delegation rights are granted to providers, the contracts require the prior written consent of both parties. However, the contracts also provide that MCOs retain their right to assign the agreements to affiliated and successor organizations without prior consent of the providers.

Exclusivity and Non-Exclusivity of Contractual Relationships

Most of the contracts specify, as illustrated in Example 9.1, that the contractual relationship between the MCO and the provider is non-exclusive, (i.e., that the MCO and the provider are free to enter into any other contractual relationships with other parties). A number of contracts are silent on this issue.[21]

Eight of the contracts, which pertain specifically to Medicare, specify an exclusive relationship. In these contracts, as shown in Examples 9.2 and 9.3, providers promise to treat in certain facilities only those Medicare patients referred by the MCO, and the MCO in turn agrees to control the development of any new facilities with which it has similar contracts. The MCO also agrees to guarantee a specific minimum number of annual Medicare patient enrollees for the contracting provider.

Resolution of Disputes

All of the contracts contain language addressing how disputes between the MCOs and the providers will be handled. Processes range from administrative review to informal mediation to mandatory arbitration. As exemplified by Examples 9.4 through 9.6, the manner in which disputes are resolved is reflective of, and affected by, the relative negotiating positions of the parties. In the mandatory arbitration Example 9.6, the MCO allows the provider to choose from

---

[21] Because of the extraordinary effect of an exclusivity clause on a provider, it is highly doubtful that a court would construe a contract that was silent on this matter as granting an MCO the exclusive right to a provider's services.

a list of three arbitrators it has identified and stipulates that the prevailing party will be responsible for all costs incurred by the arbitration.

Summary of Contract Reviews

At their most fundamental level, contracts serve to memorialize the relationship between the contracting parties by codifying in a written form the service provision and performance requirement expectations of both parties. We have found that these expectations vary widely across contracts, and in the case of MI/AD services often apply to a relatively narrow range of services that may not include integral services considered by experts to be necessary for comprehensive care. The MCOs retain extensive control over treatment decision-making and resource allocation decisions, and in cases where service duties are vaguely or ambiguously defined may expose the providers to unexpected residual liabilities. Treatment coverage decisions hinge on the interpretation of the contractual definitions of "medical necessity" and "emergency" – the absence or vagueness of such definitions in many contracts may result in significant financial risk for providers, especially those that receive capitated reimbursements.

There is a notable paucity of data reporting and performance measurement requirements in the agreements. This is especially significant in light of the growing use of capitation and case rate payment arrangements which are predicated on having reliable and timely performance information for effective care, quality, and cost management.

Providers are often exposed to extreme financial risk in many cases for failing to initiate enrollee eligibility verifications prior to providing treatment. The contracts are largely "at will" documents that permit termination and/or modification by either party under certain notice periods, however there is a trend towards the MCOs having more unilateral powers in this regard than providers do. Providers may also experience significant unreimbursed costs when the contracts specify post-termination treatment obligations without clear assurances of payment by the MCOs.

Implications and Conclusions

Implications

The findings from this analysis suggest that despite efforts to regulate the industry at the state and federal levels, managed care remains essentially the same product: a corporate structure in which a controlling entity builds a "product" (in this case, some type of prepaid health care arrangement) that contains certain features that are integral to the product that is sold.

From the MCOs' point of view, they believe it is essential that their contracts with their suppliers (in this case, their medical care providers) embody certain basic features as detailed below:

Features Sought by MCOs in Provider Contracts:

- A duty imposed on providers to provide services to the MCO's members, from the time that the MCO assigns its members to, or permits members to obtain services from, the providers, until such time as the members are no longer members of the MCO;

- Acquiescence by providers with the MCO's participation and payment terms;

- A relatively tenuous connection between providers and the MCO that can be terminated by the MCO at any time and without cause;

- An ability to modify at any time the terms of provider participation and payment, as determined by the MCO to be necessary to its own ability to serve its members;

- An ability to provide a relatively standardized product that operates in accordance with centralized controls and incentives designed to achieve relatively reliable and quantifiable results;

- Close oversight by the MCO over providers in terms of treatment decision-making, often with services that often are ambiguously described;

- Significant sharing with providers in the substantial and frequently unforeseen substantial financial risks to which the MCO itself is exposed;

- Limitations on the role providers may play in decisions about how to allocate the resources available to the MCO; and

- A willingness on the part of providers to be exposed to legal liability for the consequences of the care that is furnished, even in situations in which the provider did not make the resource allocation decision in question that allegedly contributed to an injury.

Whether these terms are fundamentally different from those that would apply to any supplier to any large, competitive, market-sensitive corporate enterprise is doubtful. Whether these terms are consistent with Americans' expectations of their medical care system is another. However, given the inconsistent nature of American expectations (i.e., a desire for the maximum available medical care for a price that may not support such expectations), it is difficult to know whether the organizing principles that we have chosen for the modern health care system are far from the mark.

At any given moment in time a small percentage of Americans are in need of significant health care resources; for them, the consequences of this competitive, risk-based, and centrally controlled system can be quite serious. For most Americans, however, the consequences of organizing health services along these principles are rarely felt, because their need for health care is simply too low to bump up against the limits created by this system.

These contracts underscore the need for attention to the sub-agreements through which managed care arrangements are actually operationalized. It is one thing to articulate rights (or at least expectations) in individual members, such as the preservation of the professional/patient relationship, access to emergency services, the provision of health care only after informed consent, access to an array of appropriate covered services, and prompt care. It is another to make these rights and expectations meaningful through oversight of the inner workings of the companies themselves. When Members of Congress have attempted to regulate the terms of the provider agreements themselves, they have been challenged as behaving in a protectionist manner toward the medical and health care professions. But a careful analysis of these contracts suggests that such attention to these inner relationships may be as, if not more, important than the listing of patient "rights" and "protections" that, even if legally enforceable, cannot be operationalized because of the countervailing force of the provider sub-agreements themselves.

Perhaps the most important recommendation that can be made in light of these findings is that purchasers pay close attention to the sub-agreements that their sellers write. Even the most expanded and detailed purchasing expectations may founder in the face of network sub-agreements that deviate from well thought-out service, access, and quality expectations. The need for strong oversight of provider agreements is particularly great in the case of purchasers such as Medicaid agencies that buy products that contain a significant number of unique features which create obligations that include a depth of services that extend beyond that in commercial plans. Where an MCO's standard provider agreement is silent on essential services enumerated in the master agreement between the MCO and the purchaser, the purchaser needs clear information from the managed care organization regarding how additional services and activities that fall outside of the provider agreement will be furnished to members.

Conclusions

Our initial study of managed care provider network agreements in 1996 revealed contracts that were built to favor the needs and demands of the managed care industry itself. The agreements we examined were constructed to shift significant amounts of financial risk onto individual health professionals, to affect their resource consumption choices through the use of powerful financial incentives such as capitation payments and withhold arrangements, and to manage and restrain providers' discretionary choices over the use of health plan benefits and services. Because agreement to these contracts was a precondition to access to patients and insurance revenues, it became evident that health professionals who wished to continue to run a practice comprised chiefly of insurance payments (as most practices are) had no choice but to sign. This sense of inevitability regarding the terms of participation was confirmed in our interviews with individual health care providers who felt that they had essentially no bargaining leverage.

Despite the passage of time, this study yields essentially the same findings. Part of this policy stasis is attributable to the inherent nature of the managed care industry. In order to run an industry that entails the acceptance of financial risk and the control over resource utilization, the managed care entities must ensure that employees and subcontractors play by the same rules. Managed care contracts cannot change significantly unless the relative balance of power between MCOs and providers also changes in fundamental ways.

However, the lack of change in the nature of these contracts should not be interpreted as passive acceptance of their terms. Over the past several years, a series of major challenges to these arrangements have been mounted in various forums, although nearly all have lost. Thus, these contracts must be understood as products of deliberate policy choices made by courts and legislative bodies alike in the face of demands for change by health care providers. In the intervening time period between our first and second studies, a series of legal challenges against these agreements have been mounted. Based on a range of legal theories, these lawsuits have sought to have the agreements voided either completely or in significant part, as void for public policy, an unlawful restraint on trade, or for other reasons. These challenges to the enforceability of provider network agreements have failed for the most part,[22] as have efforts at the national and state level to legislatively outlaw the use of contracts-at-will that create substantial financial risk and control treatment decision making. These losses in both courts and in the legislative arena underscore how resistant judges and policymakers may be to the notion of interfering with the workings of the market, particularly given the lack of data on the consequences of such agreements for patient health.

There may come a time when the industry as a whole concludes that regardless of the price concessions from suppliers, the extent to which financial risk can be downstreamed, and the controls over resource consumption that can be maintained, the business of managed care simply is not lucrative enough to justify a major investment of capital. Until the basic structure for controlling the allocation of health resources among insured Americans goes through another round of fundamental change, however, it is probably safe to assume that the contracts between managed care organizations and their provider networks may be modestly altered through negotiation, but that at the same time, their fundamental nature will survive.

[22] Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System*. op.cit.

Appendix: Examples of Provider Contract Language

Example 1.1: Contract A065: *Exclusionary Provisions*:

Exhibit A, Cost Containment Guidelines: Provider agrees to ONLY provide those services actually necessary to effectively treat an INSURED, and ONLY provide treatment that does not constitute "maintenance care." Maintenance care is defined as treatment that has no definable condition and the treatment goal is only to maintain INSURED's condition of health. Provider agrees to ONLY perform those tests which are needed to properly diagnose and treat INSURED.

Example 1.2: Contract A013: *Exceptions to Uncovered Services*:

Benefit Exceptions. Requesting additional services beyond the mental health/substance abuse maximum benefit limits is a request for a benefit exception that is intended to assist subscribers in need, such as those with a chronic and persistent mental illness. Providers may submit a benefit exception request in writing including the following information:

- Current treatment plan reflecting diagnosis, treatment goals, progress toward goals to date, required frequency of continued contact and anticipated length of care.
- Letter requesting the exception, along with clinical justification for the request. This should also include a statement of anticipated benefit for the member relative to either maintenance, prevention or a more restrictive service, prevention of decompensation, etc.

Once received, the information is clinically reviewed and a determination rendered. Providers should not assume that the request will be approved, but are advised to do clinically what is in the best interest of the patient. [in Provider Handbook as referenced by the contract.]

Example 1.3: Contract A009: *Provision of Aftercare Services:*

Facility agrees to provide Aftercare Services to all Covered Individuals who have completed any inpatient, partial hospitalization or intensive outpatient substance abuse treatment program at Facility, *at no cost to Covered Individual, [MCO] or Affiliate Payor*. Aftercare Services shall be made available, on a weekly basis, for a minimum period of six (6) months following Covered Individual's completion of said substance abuse treatment program. [Emphasis added.]

Example 1.4: Contract A013: *Prior Authorization from MCO Required*:

Neither [MCO] nor any Payer Organization shall make payment for services rendered to Enrollees which are determined by [MCO] not to be Medically Necessary or which have not been authorized by [MCO]. Provider shall, in accordance with [MCO]'s Utilization Management Program, obtain specific authorization for reimbursement from [MCO] prior to providing Covered Services to an Enrollee. In the event that Provider determines that an Enrollee requires Emergency treatment, Provider shall contact [MCO] to obtain authorization for reimbursement for such care. If an Enrollee's condition is so severe that it is not possible to contact [MCO], Provider shall provide such services to the Enrollee or refer the Enrollee to the nearest appropriate emergency facility and shall notify [MCO] as soon as practical, but not later than twelve (12) hours following such referral.

Example 1.5: Contract A020: *Primary Care Physician Authorization Required*:

In the event Participant provides services to Enrollees without the Primary Care Physician's authorization (as described in this Agreement), [MCO] will not compensate Participant for such services.

Example 1.6: **Contract A058 *Requirement for Specialty Care Pre-Authorization***:

Specialty Care Physician agrees to obtain pre-authorization from Medical Director *before performing any diagnostic or therapeutic tests, procedures or treatments on an outpatient or inpatient basis, or in any other facility.* […] Specialty Care Physician recognizes that Primary Care Physician is responsible for the coordination of Covered Person's medical care and that further referrals of Covered Person to other subspecialists or services must be made through Primary Care Physician or [MCO] Medical Director. Specialty Care Physician agrees that all referrals from Primary Care Physicians must be accompanied by an authorization. If the Specialty Care Physician wishes to schedule an additional visit for the Covered Person, he/she must seek completion of an additional referral from Primary Care Physician. If Specialty Care Physician wishes to re-refer the Covered Person to an additional specialist, he/she must obtain an additional referral from the original Primary Care Physician. If Specialty Care Physician does not obtain prior approval for the referral, Specialty Care Physician agrees not to seek reimbursement for the services from Covered Person or [MCO]. In addition, if the services of another Physician are involved, Specialty Care Physician agrees to reimburse said Physician for the services provided. [Emphasis added.]

Example 1.7: **Contract A087: *Definition of Psychiatric Emergency***:

Psychiatric Emergency means, unless otherwise provided in the applicable Health Benefit Program, a clinical condition requiring immediate intervention to prevent death or serious harm to the Member or others, or acute deterioration of the Member's clinical state such that gross impairment of functioning exists and is likely to result in compromise of Member's safety. A Psychiatric Emergency is characterized by sudden onset, rapid deterioration of cognition, judgment or behavior, and is time limited in intensity and duration. Thus, elements of both time and severity are inherent in the definition of Psychiatric Emergency. Examples of Psychiatric Emergencies include, but are not limited to, incidents presenting significant risk of serious and imminent suicidal behavior, homicidal behavior, or impulsive behavior or a dangerous nature; serious adverse drug reactions; drug-drug withdrawal (e.g., delirium tremens, Wernicke Korsokoff syndrome); psychotropic drug overdose, especially with signs of end organ distress (e.g., serious tachycardia, respiratory distress); drug-induced neuropsychiatric syndromes (e.g. akaestheia, dystonia, neuroleptic malignant syndrome, psychosis); and drug-induced systemic syndromes (e.g., acute hepatitis, priapism).

Example 1.8: **Contract A005: *Definition of Medical Emergency***:

"Medical emergency" shall mean the sudden onset of a mental health or substance abuse condition manifesting itself by acute symptoms *and one or more of the following circumstances are present*: (i) the patient is in imminent or potential danger of harming himself or others as a result of a condition included as a Covered Service; (ii) the patient shows symptoms (e.g., hallucinations, agitation, delusions, etc.) resulting in impairment in judgment, functioning and/or impulse control sever enough to endanger his or her own welfare or that of another person; or (iii) there is an immediate need for Covered Services as a result of or in conjunction with a very serious situation such as an overdose, detoxification or potential suicide. [Emphasis added.]

Example 2.1: **Contract A010:*Non-Infringement on Provider/Patient Relationship:***

[MCO] and Facility acknowledge that the facility/patient or physician/patient relationship shall in no way be affected by or interfered with by virtue of entering into this Agreement. Accordingly*, notwithstanding any other provision of this Agreement (including the definition of Medically Necessary set forth in Section II hereof),* the parties acknowledge that [MCO] exercises no control over judgments an decisions related to patient care; that all such judgments and decisions remain within the province of the Insured's Physicians and Facility; and that such Physicians and Facility remain responsible for all such decisions and judgments. In connection therewith, it is acknowledged that [MCO] exercises it judgment only concerning whether certain services are covered under a Benefits Agreement, and the extent to which payments may or may not be made thereunder. [Emphasis added.]

Example 2.2: **Contract A043:** ***Minimum Levels of Service Utilization Required:***

All Members not receiving services for 60 consecutive days are required to be disenrolled from the [MCO] system by the Contractor. […] Quarterly, the [MCO] will review the eligible members assigned to the Contractor and the members' associated service encounters. If, upon review, the number of enrolled members assigned to the Contractor who do not have a service encounter for a 60 day period exceeds 10% of the Contractors disenrollments for the given month, the Contractor will be penalized. The penalty may be up to the number of members identified by the [MCO] as requiring disenrollment multiplied by the fund specific case rate. This penalty will be deducted from the next month's capitation payment.

Example 2.3: **Contract A007:** ***Non-Disclosure of Terms of Agreement:***

The parties recognize that reimbursement rates and other aspects of the Agreement are competitively sensitive; therefore, the parties will endeavor to the extent practicable to refrain from disclosing the terms of the Agreement to unaffiliated third parties. [MCO] reserves the right to release necessary information in the Agreement if required to do so by Client Organizations or prospective Client Organizations.

Example 2.4: **Contract A021:** ***Confidentiality of Trade Secrets:***

Provider agrees that all materials, procedures and programs by [MCO], including Health Benefit Plan listings, Provider Manual, this contract, Provider fee schedules and utilization management and quality assurance programs are proprietary in nature, confidential and constitute trade secrets and shall not be disclosed to any third party without the prior written consent of [MCO].

Example 2.5: **Contract A068:** ***State Requirement for Free Communications:***

[Exhibit B to contract]: The 1997 [State] Department of Health Contract for Services between the [State] Department of Health and HMO states: The HMO must include the following language in each provider contract: 'HMO is prohibited from imposing restrictions upon the provider's free communication with Members about a Member's medical conditions, treatment options, HMO referral policies, including financial incentives or arrangements.'

Example 2.6: **Contract A077:** ***Nature of Practitioner Communications with Patients:***

11.02 Practitioner shall take necessary and appropriate actions to maintain effective provider-patient relationships with Members. Practitioner is encouraged to discuss with Members their medical and/or behavioral health conditions and treatment options and provide information required to obtain Members' informed consent to any proposed treatment or procedures, including the nature and any alternative to such recommendations. Nothing in this Agreement shall be construed to (i) restrict Practitioner from discussing with or recommending to Members any procedure or course of treatment which, in the Practitioner's professional judgment, is indicated by Member's medical or behavioral condition; (ii) require Practitioner to recommend or refrain from recommending any procedure or course of treatment that is contrary to such Practitioner's professional judgment; or (iii) prohibit Practitioner from disclosing to Members the mechanism by which Practitioner is reimbursed for Behavioral Health Services.

Example 3.1: **Contract A007:** ***Referrals to Other MCO-contracted Facilities Preferred:***

Whenever clinically appropriate, Facility shall utilize providers and facilities that have contracted either with [MCO] or, as appropriate, with a Client Organization, when arranging for additional care or care outside Facility's practice for Covered Members. If clinically appropriate services are not available from a provider or facility contracted either with [MCO] or, if applicable, the Client Organization, Facility will contact [MCO]'s case management personnel to arrange additional care.

Example 3.2: **Contract A013:** ***Coordination of Care with Primary Care Physician:***

Our commitment to quality care requires not only thorough coordination throughout the continuum of behavioral health services, but also that the member's behavioral health treatment is appropriately coordinated with the member's *primary care physician*. It is the expectation of [MCO] that there be documentation in the member's medical record that you attempted to engage the member's cooperation and permission to coordinate the member's over-all care plan with the member's primary care physician. [in Provider Handbook as referenced by the Contract] [Emphasis added.]

Example 4.1: **Contract A068:** ***Encounter-Related Data Required:***

Provider agrees to provide [MCO] in a usable form necessary for audit purposes, the data necessary for [MCO] to comply with the [State] Department of Insurance, [State] Health Care Council, and [State] Department of Health reporting requirements with respect to any services provided pursuant to this Agreement, including the following data. *Encounter-related data* requested in (i) and (ii) are provided automatically in the process of Provider's completion of the clinical and registration forms as seen within the Provider manual, and in the course of billing on standardized HCFA or UB forms.

(i) the number of Members served or assigned to Provider to receive services (including number added and terminated since the last reporting period);

(ii) service utilization data.

Example 4.2: **Contract A041:** ***Member Outcomes Data Required:***

CONTRACTOR shall cooperate with * * * in collection of information through encounter data, consumer surveys, on-site reviews, medical chart reviews, member concerns and complaints, access timelines, staff credentialing, *member outcomes*, interviews with staff, utilization and financial reports, and other data or information as required for purposes of monitoring compliance with this contract, for research and evaluation purposes, and for the purpose of developing and monitoring quality and performance objectives. [Emphasis added.]

Example 4.3: **Contract A015:** ***Provider Responsibility to Verify Members' Eligibility***:

Provider agrees that it is the Provider's responsibility to check the Division's […] eligibility system on a daily basis to determine the continuing eligibility of Enrollees for reimbursement for services rendered by Provider under this agreement. [MCO] will not reimburse for services rendered for individuals who are ineligible for services under this Agreement for any period of such ineligibility during which Provider rendered services to Enrollee. Categories of Eligibility under this Agreement are defined in the Provider Manual. Provider understands that authorization of services by [MCO] is not in and of itself a guarantee of an Enrollee's eligibility.

Example 5.1: **Contract A041:** ***Quality Assurance/Quality Improvement Process:***

(1) The CONTRACTOR'S QA/QI process shall be consistent with the particular National Committee on Quality Assurance (NCQA) Standards for Accreditation of Managed Behavioral Healthcare Organizations. (2) The CONTRACTOR'S QA/QI process shall be consistent with the State Mental Health Development Disability Services (MHDDSD) Guide to Quality Assurance and Quality Improvement.

Program Outcomes/Performance Measurement:
Access/Integration and Coordination:

- **Performance Indicator**: Members will have an initial outpatient mental health appointment to occur within three calendar days of an inpatient psychiatric hospitalization.
- **Measurement Method**: a) Review of at least 5% sample of outpatient mental health clinical files for members receiving an inpatient hospitalization; b) review of member or inpatient hospital concerns/complaints regarding access to outpatient treatment following a hospitalization.

- **Benchmark**: 98% of the sample of members discharged from an inpatient hospitalization when member/family agrees to an outpatient appointment, will have an initial outpatient mental health appointment occur within three calendar days of an inpatient psychiatric hospitalization.
- **Threshold**: In the first year, 75% of the sample of members discharged from an inpatient hospitalization when member/family agrees to an outpatient appointment, will have an initial outpatient mental health appointment occur within three calendar days of an inpatient psychiatric hospitalization.

Example 5.2: **Contract A015:** ***Quality Management Plan:***

The Quality Management Plan should include the following components:

- Quality management training for management and key personnel.
- Quality incentives (generally 5-10) with associated indicators. Generally initiatives and indicators should be chosen to reflect the categories of access, quality care and quality services. As [MCO] publishes performance standards, it is anticipated that these will be reflected in chosen indicators as well.
- Measurement of treatment outcomes and client satisfaction using a standardized tool accepted by [MCO].
- Utilization of a 'plan-do-check-act' or some similar Continuous Quality Improvement (CQI) cycle in using data to measure, monitor, and manage QI initiatives. Examples of Quality Improvement indicators related to access, care and service delivery include:
- The rate at which clients referred from acute care are scheduled for ambulatory care appointment within three days of discharge.
- The rate at which acute care Providers are contacted within 2 days following admission of an existing client.
- The rate at which same day 'urgent' care is requested and provided.
- The rate of requests made to consent to coordinate care with the primary care clinician (physician) for all new and existing clients.
- Length of time from request for an appointment or admission to the actual appointment or admission.
- The rate of actual contact with the Primary Care Clinician as a percentage of all [MCO] enrollees receiving outpatient services.
- The rate of children and adolescents who following discharges from an acute care Provider, attend at a minimum of one appointment every 30 days for a total of 120 days.
- The rate of all adults who following discharge from an acute care Provider attend a minimum of one appointment every thirty days for 90 days.

Measures:
By December 31, 1997, the Provider will have submitted to [MCO] a copy of the proposed Quality Management program and plan, and will have begun to collect data on their selected indicators.

By June 30, 1998, the Provider will have submitted to [MCO] analyses of the results of data collected as part of the Quality Management plan and program, including proposed improvement strategies or initiatives based on this data. [in Provider Handbook as referenced by the Contract]

Example 6.1: **Contract A017:** ***Case Rate Payment:***

All covered Services billed as the [treatment program name] for outpatient chemical health, shall be reimbursed at a rate of *$1,824 minus co-pay coinsurance for members who have completed* ***ten (10) or more outpatient visits***. Referral Provider shall bill [MCO] after all outpatient visits of **ten (10) or more** are completed. For members who complete **less than ten (10) outpatient visits**, reimbursement will be (96 per visit minus co-pay coinsurance. Referral Provider shall bill [MCO] after all outpatient visits of **less than ten (10)** visits are completed. Members who leave the program and are readmitted **once within thirty (30) calendar days** will be considered as one admission. All outpatient visits billed and reimbursed prior to the readmittance date will be deducted from the program rate of $1,824 **if the total number of outpatient visits incurred for both admissions are ten (10) or more**.[Emphases in text.]

[Note: This language appeared in an amendment to the contract that replaced the following payment rate: "All Covered Services for outpatient chemical health shall be reimbursed at a rate of $32.00 *per hour* minus copay or coinsurance for all completed outpatient visits."] [Emphasis added.]

Example 6.2: **Contract A018:** ***Case Rate Payment:***

All Covered Services for outpatient chemical health shall be reimbursed as follows: [treatment program name]: $1,856 contract rate – copay or coinsurance, coordination of benefits, deductible payments = [MCO] payment. A Program is defined as *20 visits or 58 hours of covered outpatient chemical health services.* In the event the Covered Person does not complete the Program, [MCO] will reimburse Referral Provider at a rate of $32.00 per hour minus copay or coinsurance for all completed outpatient visits.

Example 6.3: **Contract A042:** ***Capitation Agreement:***

As a participating [treatment program name], Provider agrees to the following:

1. Bear all financial responsibility for outpatient Covered Services provided to Health Plan Members reimbursed under the monthly variable risk allocation (MVRA) or any other services reimbursed as delineated under 'Other Rates.'
2. Diligently and cooperatively work with [MCO] to assure access to all Health Plan Members within the standards of access to outpatient services as delineated in the [MCO] Agreement.
3. Agree to participate in the inpatient withhold pool as follows:
   - [MCO] shall establish an Inpatient Fund for each Health Plan at a specified percentage (23.5%) of the monthly capitation payment received from the Health Plans.
   - Any year-end savings from the Inpatient Funds will be shared with participating [health plans]. Initial distributions will be made four months after the end of the contract year. Final distributions shall not exceed twelve months after the end of the contract year.
   - At any point that it is determined that the Inpatient Fund set aside is at risk of not being sufficient to cover inpatient costs incurred, the Outpatient Fund will be decreased by the percentage amount necessary to cover additional inpatient costs for the next month's MVRA distribution. [MCO] may make this deduction across all or some portion of counties providing services to the particular Health Plan Members.
   - At any point that it is determined that any corrections to the Inpatient Fund are no longer necessary to cover additional costs, the Outpatient Fund will be increased to return the Inpatient Fund to 23.5% for the following month MVRA distribution.

Example 6.4: **Contract A043:** ***Appears to be a Capitation Contract Although Termed a Case Rate Contract:***

Case Rate. Contractor will be funded on a monthly basis. The gross case rate will be equivalent to the capacity defined in this Subcontract, multiplied by the fund specific case rate. Assuming actual enrolled members do not fall below 85% capacity for SMI members and 90% capacity for children, the total funded amount will remain constant. In the event actual assigned members fall below the thresholds described above, [MCO] retains the right to review for consideration of appropriate adjustment of Contractor's capacities and/or case rates. In the event assigned/enrolled SMI Members of Children exceed 110% of system capacity, the [MCO] and the Contractor shall review and may consider adjustments as appropriate. The [MCO] also may adjust capacity downward if enrollment decreases are due to member dissatisfaction or other quality or programmatic issues, resulting in increased assignments to other contracted Contractors. […] The gross case rate funds will consist of the capacity payment and a withhold for a pharmacy pool. […] In order to determine the At-Risk Providers pharmacy withhold amount, [MCO] will apply the most current pharmacy cost data against the At-Risk Provider's gross case rate distribution. [MCO] will pay the Pharmaceutical Benefit Management (PBM) company on a biweekly basis for all pharmacy costs related to [MCO] members from the respective At-Risk Provider withhold amounts. Once the actual pharmacy cost data is received for each respective month, the applied withhold for that month will be compared to the actual pharmacy costs for that month and an adjustment made to zero out any variances. Any variances (+/-) will then be applied as part of the current month's pharmacy withhold.

Example 6.5: **<u>Contract A088</u>*<u>: Appears to be a Capitation Agreement, Although Titled "Case Rate":</u>***

6.1.1. The [MCO] has established *** the monthly case rates and bed day allocations for [enrollees]. The PMPM payment amounts, after the withholding of amounts specified in section 6.7 and 6.8 are specified in 6.1.2 below.
6.1.2 PMPM payments ***
a. $172.08 pmpm for tier A
b. $463.92 pmpm for tier B
c. $895.42 pmpm for tier C
d. $1602.20 pmpm for tier D
e. $2493.53 pmpm for tier E
f. $5780.29 pmpm for tier F

Payments to the lead provider [Note: this term is not defined] shall consist of the number of enrollees in each tier multiplied by the tier amount specified in 6.1.2 less deductions as specified in 6.1.3, 6.1.4 and/or 6.3.
6.1.3 Medicaid reimbursement for mental health services provided by the lead provider or other mental health certified provider shall be deducted from the projected pmpm for members. Payment and deductions shall be carried out as set forth in Appendix A of the Case Rate Procedures Document. The lead provider shall be paid for all Medicaid services and shall receive the difference between the projected pmpm and the actual Medicaid payment.
6.14 payments under this section may be modified as necessary to implement the requirements of this *** contract or to make adjustments based on insufficient funds or revenues for payments required ***. The *** shall provide notice of any modification under this section as soon as is reasonably possible but in no event shall such notice be less than 45 days prior to the proposed modification. ***
6.7 Case Rate Management Fund
6.7.1 The *** shall withhold an amount of not more than 5% of the case rate which shall be held by the *** and designated as the Case Rate Cost Management Fund ***.
6.7.2 The lead provider may access funds from said Case Rate Cost Management Fund in accordance with procedures set forth in the case rate procedures document.
6.8 Case Rate Incentive Fund
6.8.1 The *** shall withhold an amount of not more than 2% of the total amount of the case rate which shall be held by the *** and designated as the Case Rate Incentive Fund.
6.8.2 The lead provider may access funds from the case rate incentive fund in accordance with a methodology determined by the *** and in consultation with providers.
6.9 Cost management thresholds
***
(b) In the event that the lead provider's non-Medicaid expenses are less than the non-Medicaid case rate payment, the following shall apply:

(i) the lead provider may retain an amount equal to the difference between such amounts or $30 per member per month, whichever sum is lower.

(ii) If the difference between the amount is greater than $30 per member per month, the amount shall be deposited in the case rate management fund.

(b) In the event that the lead provider's non-Medicaid expenses exceed the non-Medicaid case rate payment, the following shall apply:

(i) the lead provider shall be liable for an amount equal to the difference between such amounts or $30 per member per month, whichever sum is lower.

(ii) if the difference between such amounts is greater than $30 per member per month, the amount in excess of $30 per member per month shall be paid through the case rate management fund.

Example 6.6: **<u>Contract A061:</u>** ***<u>Settlement of Outstanding Claims in Event of MCO Insufficiency of Funds:</u>***

Provider acknowledges that Network's funds for payment for Covered Services rendered to Members pursuant to this Agreement are not unlimited. Provider further acknowledges that as a member of [MCO], Provider is responsible for providing Covered Services to Members. If funds for payment are exhausted and [MCO] will be unable to make payment for services rendered, Provider and [MCO] will work to develop a mutually agreed upon settlement, if possible, of outstanding claims.

Example 6.7: **<u>Contract A077: *Discounted Fee-for-Service*</u>***:*

REIMBURSEMENT: The reimbursement for Behavioral Health Services shall be the lesser of:

a. Seventy percent (70%) of Practitioner's reasonable and customary charges in effect on the date the Behavioral Health Service was provided; or

b. The fee schedule (the "Fee Schedule") set forth in Attachment C-1

c. Billed charges

Less applicable Copayments, Coinsurance, Deductibles and coordination of benefits recoveries. Practitioner agrees that such compensation (when added to applicable Copayments, Coinsurance, Deductibles and coordination of benefits recoveries) constitutes payment in full for all Covered Services provided to Members.

Example 6.8: **<u>Contract A041:*Risk Reserve and Incentive Pool*:</u>**

Payments from the Risk Reserve and Incentive Pool will be made for incentives which will be identified in the NETWORK MANUAL (e.g., submission of complete, accurate and timely encounter data; incentives for consumer satisfaction and positive clinical outcomes; incentives for achieving quality management indicators) on a basis specified in the NETWORK MANUAL. Payments may also be made from this Pool for investments in services system development on a basis to be determined.

Example 7.1: **<u>Contract A002: *Without Cause Termination by Either Party:*</u>**

[MCO] or Provider party may terminate this Agreement without cause upon ninety (90) days prior written notice of termination to the other party.

Example 7.2: **<u>Contract A052: *MCO Right to Not Renew Contract:*</u>**

[MCO] has complete and unfettered discretion to reject the automatic renewal of this Agreement for any reason sufficient to [MCO] to justify or support such action.

Example 7.3: **<u>Contract A039: *MCO Right to Terminate for Provider Misrepresentations:*</u>**

It is understood by Organizational Provider that [MCO] has the right to terminate this Agreement if [MCO] finds that an agent of Organizational Provider is making statements, either written or oral, which are false or 'maliciously critical' and which are intended to injure [MCO]'s reputation and relationship with Members. It is further understood by Organizational Provider that [MCO] has the right to terminate this agreement with Organizational Provider if [MCO] finds that an agent or representative of Organizational Provider is making material misrepresentations regarding the terms, provisions, or requirements of [MCO]'s various plans and Covered Services.

Example 7.4: **<u>Contract A054: *MCO Right to Terminate for Provider Non-Performance*</u>***:*

[MCO] may terminate this Agreement immediately upon the occurrence of any of the following: (1) PROVIDER fails to provide satisfactory evidence of or fails to maintain any license or certification required to provide Covered Services; (2) PROVIDER fails to provide satisfactory evidence of or fails to maintain any insurance required by this Agreement; (3) PROVIDER willfully breaches, habitually neglects or continually fails to perform professional duties; (4) PROVIDER commits or fails to commit an act which is determined by [MCO] to be detrimental to the Participant or to the reputation, operation or activities of [MCO] or Payor; (5) an administrative finding or judgment of professional misconduct on the part of PROVIDER or PROVIDER's Professional Staff; (6) PROVIDER breaches the Agreement after notice and cure of a similar breach or there has been a total of three breaches of the Agreement in the twelve (12) months prior to the third breach; (7) [MCO] becomes aware of prior license/certification sanctions or unsatisfactory malpractice history. [MCO] may suspend referrals to and/or reassign Participants from PROVIDER pending investigation of the alleged occurrence of the event(s) listed in this paragraph, and [MCO] shall notify PROVIDER in writing of [MCO]'s election of its right pursuant to this sentence.

Example 7.5: Contract A019: *60 or 30 Days Termination Notice:*

This Agreement may be terminated by the Provider or [MCO], upon 60 days written notice to the other party, for material failure of the other to comply with any of its terms and conditions. Upon receipt of such termination notice, the party alleged to be in breach of this Agreement shall have 30 days to cure the breach. Failure to cure the breach within 30 days shall result in termination of the Agreement, effective 60 days following the initial termination notice.

Example 7.6: Contract A020: *125 Days Termination Notice:*

[MCO] shall have the absolute right, exercisable in its sole discretion at any time after the effective date of this Agreement upon one hundred twenty-five (125) days written notice to Participant, to terminate this Agreement and all of Participant's respective rights and obligations under this Agreement, with or without cause, effective as of the date specified in the written notice. Participant shall have to absolute right, exercisable in his/her sole discretion at any time after the effective date of this agreement, upon one hundred twenty-five (125) days written notice to [MCO], to terminate this Agreement and all of Participant's respective rights and obligations under this Agreement. *[Note: Language is silent on whether Participant's termination rights can be exercised with or without cause.]*

Example 8.1: Contract A002: Payment Methodology for Post-Termination Treatment:

Upon request of [MCO], Provider shall continue to provide Medically Necessary Health Services to Members who are receiving such services from Provider as of the date of termination of this Agreement. Said services shall be in accordance with this Agreement until the Member has been transitioned by [MCO] to another Participating Provider, except that [MCO] or Payor shall pay Provider for such services at Provider's Customary Charges.

Example 8.2: Contract A103: Responsibility of Provider to Transfer Care in the Event of Termination:

"PRACTITIONER agrees that in the event of his or her termination of this Agreement to continue to provide Covered Services to a Member who is under active treatment until the episode of illness, injury, or other debilitation requiring the provision of Covered Services is completed, or responsibility for such treatment is assumed by another participating practitioner, or the member ceased to be eligible as a Member, whichever occurs first. *Upon suspension or termination of this Agreement by either party, PRACTITIONER shall use his or her best efforts to transfer care of Members to another participating practitioner as soon as thereafter as practical*. The parties agree that nothing in this Agreement authorizes the practitioner to abandon any Member who is a patient." [*emphasis added*]

Example 9.1: Contract A062: *Non-Exclusivity of Agreement*

Non-Exclusivity: This Agreement is not an exclusive Agreement between [MCO] and PROVIDER. It does not require [MCO] to refer any minimum number of Participants to PROVIDER.

Example 9.2: Contract A026: *Exclusivity of Medicare Line of Business:*

Provider is not permitted to contract or affiliate with any Competitive Plan which offers a Medicare HMO product which will be provided to members of the Competitive Plan at the same facility where services are provided to members of [MCO]. Provider may contract or affiliate with a Competitive Plan which offers a Medicare HMO product which will be provided to members of the Competitive Plan at a facility which is not affiliated with [MCO] and which is a reasonable distance from the Provider's facility under this Agreement. Provider may contract or affiliate with a Competitive Plan which does not offer a Medicare HMO product at any facility. [MCO] reserves the right to determine which Competitive Plans offer Medicare HMO products and to prohibit Provider from contracting or affiliating with such plans at the facility under this Agreement, or at facilities within a reasonable distance from this facility.

Example 9.3: **Contract A027:** ***MCO Guarantee of Medicare HMO Referrals:***

[MCO] will not allow the development of another [MCO] contracted primary care medical center within a one (1) mile radius of the [Provider Name] contracted facility. Furthermore, [MCO] guarantees that within a two year period following the opening of the [Provider Name] contracted facility, whose physicians maintain open panels and achieve average or above average customer satisfaction ratings, a minimum of 500 Medicare HMO enrollees will be enrolled per each physician necessary to treat the center's assigned enrollees for a period not to exceed twelve (12) months or such time that membership reaches 500 Medicare HMO enrollees.

Example 9.4: **Contract A042:** ***Administrative Review:***

Provider shall have a right to appeal through an *administrative review* process to [MCO] actions or decisions concerning the interpretation of this Agreement. […] Within 60 calendar days of receiving the request for an administrative review, the [MCO] Director shall send a written decision resulting from the administrative review to the Provider. The decision of the Director shall be binding. [Emphasis added.]

Example 9.5: **Contract A018:** ***Informal Mediation:***

Dispute Resolution. In the event any dispute between the parties arises out of this Agreement, the parties shall meet and confer in good faith to resolve such dispute. In the event such efforts do not resolve the dispute within thirty (30) days from the date the parties first met to discuss it, the parties shall submit the dispute to *informal mediation* before a mediator mutually agreeable to the parties. If the parties are unable to agree on a mediator or if such mediation does not resolve the dispute, the parties may pursue any available legal or equitable remedies. [Emphasis added.]

Example 9.6: **Contract A055:** ***Mandatory Arbitration:***

Mandatory Arbitration: The parties agree that any controversy or claim arising out of or relating to this Agreement (and any previous agreement between the parties if this Agreement supersedes such prior agreement) or the breach thereof, whether involving a claim in tort, contract or otherwise, shall be settled by final and binding arbitration in accordance with the provisions of the Federal Arbitration Act. The parties waive their right to a jury or court trial. […] *[MCO] shall provide Provider with a list of three neutral arbitrators from which Provider shall select its choice of arbitrator for the arbitration.* Each party shall have the right to take the deposition of one individual and any expert witness designated by the other party. At least 30 days before the arbitration, the parties must exchange lists of witness, including any experts, and copies of all exhibits to be used at the arbitration. Arbitration must be initiated within 6 months after the alleged controversy or claim occurred by submitting a written demand to the other party. The failure to initiate arbitration within that period constitutes an absolute bar to the institution of any proceedings. Judgment upon the award rendered by the arbitrator may be entered in any court having jurisdiction. The decision of the arbitrator shall be final and binding. The arbitrator shall have no authority to make material errors of law or to award punitive damages or to add to, modify or refuse to enforce any agreements between the parties. The arbitrator shall make findings of fact and conclusions of law and shall have no authority to make any award which could not have been made by a court of law. *The prevailing party, or substantially prevailing party's costs of arbitration, are to be borne by the other party, including reasonable attorney's fees*. [Emphasis added.]