Negotiating managed care contracts: Common

Managed care contracts are an integral component of the healthcare system, influencing cost, quality, access and the overall management of healthcare services. However, navigating the complexities of these agreements can be difficult and often frustrating for office staff and providers.

OMSs must have a thorough understanding of their contracts' details – such as termination clauses, provider obligations and fee schedules – to comprehend how they may affect reimbursement. For instance, claim denials or payment limitations could stem from the terms of a provider contract, rather than the payer's policy itself. Additionally, the payer's policy and other documents often are incorporated by reference in the contract, which means they would be treated legally as part of the contract itself.

While managed care contracts vary, there are some clauses often found in provider agreements throughout the industry. The following are common clauses OMSs may encounter.

■ **Non-covered services** – Some OMSs might experience scenarios in which a payer stipulates a provider may only bill the patient the contracted rate for services deemed non-covered. This occurs due to clauses in certain managed care contracts requiring adherence to the payer's fee schedule, even for procedures classified as non-covered under the plan.

Forty-two states have laws that generally prohibit a payer from limiting or capping the provider's fee for non-covered services. These laws can differ from state to state, and certain exceptions may apply, such as waiting periods, annual maximums and frequency limitations.

Many non-covered services laws took effect within the last 13 years. If the provider's contract was signed prior to the law's effective date, the contract terms likely do not protect the provider from fee capping. Therefore, a provider may be obligated to accept the discounted rate even for non-covered services, in which case the OMS may consider updating or renegotiating their contract.

Note that state insurance codes may not apply to all plans. For example, self-funded plans, also known as Employee Retirement Income Security Act (ERISA) plans, are regulated under federal law and typically fall outside the scope of state insurance mandates, including non-covered services laws.

■ **Disallow clauses** – Disallow clauses prevent contracted providers from billing their patients for services, even if the treatment has been deemed medically necessary by the OMS. Plans may disallow a procedure and deny it as a non-covered service by stating it is not necessary or in line with general practice standards or may consider it inherent to another procedure, such as an extraction with an alveoloplasty.

Disallow clauses typically indicate that not only does the insurance plan not pay for the service, but the OMS also is not permitted to bill the patient for it. If a plan disallows benefits and the provider is prohibited from balance billing the patient, it is likely the provider's contract includes a disallow clause.

■ **Medicare exclusions and provider obligations** – Whether a provider is participating, non-participating or opted-out with Medicare, it is important to understand the contractual obligations linked to status choice. Medicare participation status determines how services are reported, for what and how much a provider may charge the beneficiary, and whether a private contract or an Advanced Beneficiary Notice of Non-coverage is required before moving forward with treatment.

clauses that can impact OMS billing

Additional information about Medicare enrollment options and billing requirements is available at AAOMS.org/CodingReimbursement.

■ **All-products clauses** – All-products clauses generally stipulate that if an OMS agrees to participate in any specific plan offered by a managed care organization (MCO), they also must participate in all other health plans offered by that MCO. Many MCOs provide a range of insurance products, including HMO, PPO, Point of Service, Medicare and indemnity plans to various populations. Therefore, by agreeing to an all-products clause, a provider may inadvertently commit to accepting all types of insurance programs offered by the MCO.

When patients with insurance obtained through state marketplaces visit a practice, existing managed care agreements might automatically enroll the provider in the marketplace plan as a participating provider, especially if an all-products clause is included in the contract.

All-product clauses may affect dental contracts if the provider has opted out of Medicare. For example, if a provider has a contract with a dental plan that also offers Medicare Advantage benefits and their contract includes an all-products clause that mandates participation with all the insurer's plans, including the Medicare Advantage dental plan, OMSs could potentially violate the managed care contract by opting out of Medicare.

However, since 2022, CMS policy has permitted opted-out providers to receive reimbursement for Medicare Advantage supplemental benefits, such as benefits for routine dental care or certain dental procedures excluded under Part A and Part B. This policy does not apply to services covered under traditional Medicare; however, it may allow opted-out OMSs to participate in Medicare Advantage dental supplemental benefit networks. OMS staff must carefully review a beneficiary's benefits to determine whether the policy will cover the service or whether the patient may be financially responsible.

Some states prohibit MCOs from including all-products provisions in provider contractual agreements. However, keep in mind state insurance codes may not apply to all plans, such as self-funded plans.

■ **Rental network (or silent) PPOs** – Some MCOs may permit insurers to sell or rent a provider's fee schedule to other entities, creating what is sometimes referred to as leased networks. When MCOs do this, providers may find their negotiated payment discounts with one insurer being accessed or applied by other parties. This sharing of discounts can lead to rental network arrangements in which the provider's negotiated discounts may be accessed by the entities associated with the network, such as other payers, affiliated plans or, in some cases, third-party non-payers or "repricers."

If providers sign a contract with a rental network PPO – also called a silent PPO – they also may unknowingly have agreed to accept negotiated, discounted rates from the payers or other entities renting the fee schedule. Some states have enacted laws that either prohibit or limit silent PPOs, but applicability may depend on the type of plan.

It is important to note that claim rejections or restrictions on payments also can stem from the patient's benefit plan, apart from what is stipulated in the provider's contract. For instance, while a payer may allow coverage for a certain procedure or condition, the patient's benefit package may state otherwise. For this reason, OMSs should be familiar with the patient's benefits summary and monitor payer websites and reimbursement policies for relevant changes.

Negotiating a managed care contract requires preparation, collaboration and compromise. AAOMS encourages members to discuss and review their contract negotiations with their practice attorney and thoroughly review and understand all contracts before entering into an agreement with a third-party payer. ■