

Managed Care Contracting – A Primer

What is managed care and why are contracts involved?

Simply stated, managed care is the predominant form of healthcare insurance supported today in the United States. Whether the healthcare plan is based on collections of doctors and hospitals organized into HMO's, PPO's, POS's, or other alphabet labeled organizations, all plans share in common the concept of agreed upon payment structures using contracts.

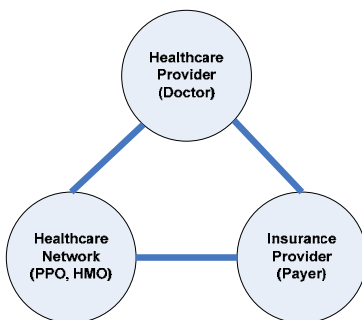
Contracts define the prices that healthcare providers will accept for services rendered to people covered by the healthcare plan. These contracts may contain simple fixed fee agreements (such as \$36 for an office visit) or they may be more involved based upon what disease condition is being treated or length of stay involved for in-patient hospital care. Other fee provisions are common, as well.

In all cases, contracts allow both the insurance company and the healthcare provider to have an understanding in advance of treatment about what the cost of services ultimately will be. This is a good arrangement for both parties. It ensures that the healthcare provider is appropriately paid for medical services and that the insurance company can set premium amounts at levels to allow them to fund these payments.

If contracts did not exist, then healthcare providers could set their charges at varying amounts. Since the practice of medicine historically has not been one in which people price-shop for bargains, the cost of treatment generally is not discussed before the provider completes the delivery of care. Patients (and their insurance companies) risk being surprised when they get the bill if there is no established reimbursement schedule available for review prior to treatment.

Who negotiates these contracts?

Usually, networks and providers are the parties that enter into contractual agreements concerning reimbursements for healthcare services. Refer to the chart below to see the relationships of all parties involved.



First, a healthcare network must be built. Whether it is an HMO, a PPO, or some other network arrangement, an organization is created to assemble providers into a unique group collectively called a "network". Depending on the

type of network, providers may have their backgrounds

checked and their credentials reviewed before they are allowed into the network. All participating providers must agree to certain fee schedules for reimbursement. Other contractual conditions may also apply, some on the part of the provider and some on the part of any insurance plan that uses the network to identify providers they will recommend to their insured members.

Next, the network seeks out insurance companies and other organizations that pay for provider services (payors or payers). Payors agree to encourage their members to use providers contracted with the network in order to ensure that fees for services are paid at contracted amounts. Payors must agree to pay providers within a certain time period in order to receive reduced charges as payment-in-full. The arrangement works well for all parties. The insurance company saves money on payments which it can then use to lower the premium costs and thereby benefit the patient. The provider benefits because patients they might otherwise not see are encouraged by the healthcare plan to use providers with contracts.

As more and more payors use a network in a given geographical area, the network can leverage the higher number of potential patients in order to achieve better discounts from participating providers. The more insured members a plan has, the greater the value to the provider, and the better discounts the provider is willing to offer. The better the contractual discounts are, the more payors (and potential patients) the network can attract, and the cycle repeats.

How are contracted amounts identified?

When providers submit their bills to payors, it is a general practice for the bill to show the retail price without any discounting. The payor or a third party researches the network contracts to determine the contracted rate for the services rendered. The provider, the insured member, and the healthcare plan all are advised of the contracted amount due through the EOB (Explanation of Benefits) or the EOP (Explanation of Payment) text. After an adjustment to the retail price for services is made, then the financial benefits the insured member is entitled to are adjudicated and the amount of money both the insurance company and the insured member must pay are calculated.

In the example below, a **Total Charge** of \$82.00 was discounted through contract by an **Excluded Amount** of \$12.86. The insurance plan paid (**Paid Amount**) \$44.14 and the patient paid a \$25.00 **Copayment/Coinsurance**.

Claim Line 1							
Service Date	Service Code/Description	Status	Total Charges	Paid Amount	Excluded Amount	Deductible	Copayment / Coinsurance
03/10/2008	92012/OPHTH SERV: MED EXAM & EVAL, 1	PAID	82.00	44.14	12.86	0.00	25.00 / 0.00