Q & A:
Contracting in Colorado After Passage of Landmark Legislation

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After years of hard work, Colorado Medical Society was successful in securing the passage of the nation's first fair and transparent managed care contracting legislation. Codified at CRS §25-37-101, *et. seq*., the law became effective January 1, 2008 for new contracts and requires existing contracts to be in compliance no later than December 31, 2008. An exception to the effective date was given to domestic non-profit health plans (Rocky Mountain Health Plans and San Luis Valley Health Plans), which have until December 31, 2009 to come into compliance. The following are answers to some of the most frequently asked questions about the law.

Q: Who is Covered by the New Law?

A: The law applies to all contracts between a "person or entity" and "a health care provider." A "person or entity" is one with a primary business of contracting with health care providers for delivery of health care services. A "health care provider" includes physicians, dentists, pharmacists, and nurses, as well as, ambulatory surgery centers, pharmacies, and professional corporations. The law does not apply to contracts with hospitals or joint ventures involving hospitals, employment or other agreements between providers, the government and its agencies (e.g. Medicare, Medicaid), exclusive contracts with a single medical group in a specific geographic are (e.g. Kaiser), or pharmacy benefit management companies.

Q: Are Medicare Advantage Plan Contracts Covered?

A: Yes.

Q: What does a Managed Care Contractor Need to Disclose Under the New Law?

A: The law requires managed care contractors to provide a summary disclosure form with the contract that includes:

- Compensation and payment
- Categories of coverage
- Duration of the contract and termination provisions
- Responsible person or entity processing claims
- Required dispute processes
- List of any contract addenda

The disclosure must be written in "plain language." Although information in the disclosure form is not considered part of the contract; the law requires the disclosures to "reasonably summarize" the terms of the contract.

Q: How Specific Does the Compensation and Payment Disclosure Need to Be?

A: Payors must summarize the manner of payment (e.g. fee for service, capitation, risk sharing). Additionally, payors must disclose the methodology to be followed for calculating payment and the date of any change in the methodology (e.g. RVU system and conversion factor with any adjustments, including geographic factors; percentage of Medicare; or percentage of billed charges).

Q: Are Payors Required to Use the Medicare Fee Schedule or Resource Based Relative Values Scale (RBRVS)?

N: No. The law does not require use of any particular payment system or methodology. Rather, the law requires that the system or methodology used be disclosed.

Q: Do I Get a Fee Schedule?

A: Yes. Payors must provide a fee schedule for the codes expected to be used under the contract when they present the contract. Providers may also request the fee schedule for other codes. A fee schedule must also be provided with any material changes to the contract. Although the fee schedule may be provided electronically, you are entitled to a hardcopy fee schedule upon request up to twice annually.

Q: Can a Payor Change a Contract without Approval?

A: It depends upon whether a change is "material." Under the law, a material change is defined as a change that decrease provider payment/compensation, alters administrative procedures in a way that is reasonably expected to significantly increase provider expense, replaces the maximum allowable cost list for prescriptions, or includes a new category of coverage. Importantly, a change is not material if the change is identified in the original contract. For example, if payment is based on a percent of the Medicare fee schedule, which is subject to change during the term of the contract.

A material change requires 90 days notice titled "Notice of Material Change to Contract" and provides a process for a provider to object to the change. For changes that are not material, the payor may simply give 15 days notice.

Q: What if I Object to a Proposed Change?

A: A provider may object to a proposed material change in writing within 15 days. Although the law does not specify, the 15 days arguably begins with the date the notice of change is postmarked. If the objection is not resolved between the payor and provider, either party may terminate the contract upon written notice provided at least 60 days before the effective date of the change.

If the proposed change is to add a new category of coverage, a provider may object to the category, and such objection is not a basis for termination. Rather, the contract continues without the new category.

Q: Can I Terminate the Contract for Other Reasons?

A: It depends on what the parties agree to in the contract regarding termination. Regardless, the new law requires any contract that allows termination for cause to state what constitutes cause. Further, if a contract is for a term of less than two years, it must provide for termination without cause upon 90 days notice.

Q: Can I Close My Practice to New Patients?

A: Yes, if you provide 60 days written notice and state the reason. New patients are patients who have not received services during the last three years (regardless of change in insurance).

Q: Does the Law Require New Contracts?

A: No. Payors may bring existing contracts into compliance (by providing disclosures and amending any noncompliant terms). Payors are not required to negotiate new contracts with providers.