Published on *The National Law Review* https://natlawreview.com

Managed Care Issues in Corporate Transactions

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For most organizations furnishing reimbursable health care services, commercial third party payors (Payors) likely constitute the single largest source of revenue for the organization. This trend is likely to continue as the Centers for Medicare and Medicaid Services (CMS) transitions more and more Medicare beneficiaries into Medicare Advantage and as states look to Payors to manage Medicaid benefits. Given their key role in the financial potential of an organization, managed care contracts with Payors should be carefully reviewed during the course of a corporate transaction to identify and correct potential pitfalls early in the process to ensure a seamless transition at closing. The list of essential managed care issues to analyze will depend on the type of transaction, whether the organization is the buyer or the seller, the nature of the organization's managed care contracts, and the timing of the transaction. We outline four issues here that warrant special attention in any corporate transaction.

I. Identify Missing Documentation

The diligence process for every transaction will involve identifying missing documentation. But gathering and reviewing documentation for managed care contracts can be particularly challenging. Many managed care contracts provide that the Payor may unilaterally amend the contract, including its reimbursement rates – contractual posture that is anathema in other types of contracts. To make things more difficult, the amendment may not be transmitted in the form of a formal, standalone, written contract amendment. Instead, some amendments may be transmitted by a Payor via email or even simply posted on Payor websites. These amendments need to be gathered and reviewed because of their potential to materially affect reimbursement or the fundamental relationship between the parties.

II. Beware Antitrust Liability

Unlike most of an organization's contracts, managed care contracts likely include competitively sensitive information. In 2018, the Federal Trade Commission (FTC) warned parties to take steps to avoid creating antitrust liability by improperly exchanging competitively sensitive information during premerger negotiations, due diligence, or the integration planning process. The FTC offered a number of suggestions to reduce antitrust liability, but one of the most common in health care transactions is the use of internal "clean teams." Clean teams are limited groups of individuals from both parties to a transaction that have access to competitively sensitive information but, importantly,

are not involved in day-to-day operations. The best practice is for managed care contracts to be shared only with and reviewed only by clean team members.

III. Observe Payor Notice or Consent Requirements

Contractual restrictions on assignment are routinely tracked during due diligence for all of an organization's written agreements, from real estate leases to employment arrangements. For managed care contracts, assignment by the health care provider is commonly prohibited without the written consent of the Payor. Occasionally, these provisions even define an "assignment" to include stock transactions. For many transactions, a plan is needed for the seller and buyer to jointly approach Payors prior to closing to seek consent.

In addition, there are other notice or consent requirements that are fairly unique to managed care contracts. It is not uncommon for Payors to require notice of or the right to consent to certain changes within the health care provider organization including, for example, changes in ownership (even indirect ownership), changes of directors or other key employees, or material changes to the health care provider's scope of services. These additional notice or consent requirements may be triggered regardless of the structure of the transaction.

IV. Other Communication and Coordination with Payors

Even when not required by law or managed care contract, it is often a good idea to communicate early with Payors regarding a transaction to ensure a smooth transition. Many transactions require Payors to make changes in their systems in response to the transactions to address things such as health care provider name, tax identification number, national provider identification number, electronic funds transfer information, facility location information or any other demographic or credentialing information of the health care provider. Notice of these types of changes to the Payors may not be required by contract or law but the practical reality is that failure to update any of this information in the Payors systems may affect payment. The fact is that many Payors are large bureaucracies, slow to respond to health care provider requests. Early communication and coordination with Payors on these smaller details may be critical to a smooth transition after the transaction closes.

Conclusion Managed care contracts are not just another group of contracts to be handled by the normal corporate due diligence process. In corporate transactions involving health care organizations both the buyer and the seller have an interest in paying special attention to the managed care contracts. The buyer wants to know that the numbers it sees on financial statements are supported by reliable managed care contracts that can be transferred at closing without a delay or negative impact on cash flow. The seller wants to provide sufficient documentation of its managed care contracts to avoid a reduction in purchase price or any hiccups that might jeopardize closing. Since they are often the most important source of revenue for an organization, managed care contracts warrant special attention well in advance of the transaction closing.

National Law Review, Volume IX, Number 304