The modern payer contract

What Medicare's proposed new fee-for-service system means for you

BY ALICE G. GOSFIELD, ESQ.

Every month, Dermatology World *covers legal issues in Legally Speaking. This month's author, Alice G. Gosfield, Esq., is a health care attorney at Alice G. Gosfield and Associates, P.C.*

Many physicians who have been in practice for a while remember the backlash against managed care in the late 1990s with talk of "drive-by deliveries" and the eruption of spontaneous applause in movie theaters when Helen Hunt complained in *As Good As It Gets* about how her health plan would not pay for her son's medical care. Americans protested against narrowed networks, which have recently resurfaced in a more substantial way.

With today's emphasis on the health care system producing improved value — lowered costs with better quality and better patient experience of care — the managed care payers are similarly under the gun. The modern payer contract still retains many of the traditional features of the contracts of 20 years ago. However, there are new types of provisions that reflect the changed context.

Context

For dermatologists contemplating payer contracts, one of the most significant issues will be whether they are practicing as part of a large multi-specialty group which includes primary care physicians or in a health system. In those settings, dermatologists will have little say about their contracts, which will reflect the larger entity's broader concerns. In a stand-alone dermatology practice the ability to negotiate terms will turn on the size of the group, its importance in the local market for patient access, and the extent to which it can demonstrate value. Still, all physicians should understand the contracts which determine payment for their services.

Another element of context is whether applicable state regulation imposes restrictions regarding what payers are allowed to do. In response to the complaints of the late '90s, many states adopted consumer and provider protective statutes and regulations that must be confronted by the payers in their contracts. In some states, such as New York, there are "magic words" that are required in three- and four-page addenda to any provider participation agreement. A third element of context is that the participation agreement may not actually be with a payer at all, but rather with a clinically integrated network, an IPA, an ACO, or some other consolidation of providers that will itself contract with the payer directly. Because the provider participation agreements will have to reflect what the network agrees to with the payer, the provider participation agreements mirror much of what exists in the network payer contract.

Standard provisions

There are core standard provisions in virtually all of these agreements that do not deal with compensation and do not change very much. The first among them is the beneficiary hold harmless provision which says that the payer arrangement is the only mechanism by which the provider gets paid for covered services; and under no circumstances, even the bankruptcy of the payer, may the provider charge a patient for a covered service. Every contract imposes a condition of medical necessity for all services, except those preventive or screening services that may be included as covered services.

Most participation agreements require physicians to provide 24-hour coverage for their services

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and not discriminate against patients based on their being insured by the payer. The provider is obligated to cooperate with the plan's systems dealing with utilization management, quality assurance, credentialing, subscriber grievances, record-keeping, and claim submission.

The physician will be required to carry malpractice insurance and will be required to maintain a state medical license. Most payers today require board certification. The physician will be obligated to charge co-payments and deductibles to patients, will agree to be listed in a directory, and will be obligated to cooperate with coordination of benefits when there are multiple payers who are primary and secondary.

Typically the contracts require physicians to make in-network referrals, maintain the confidentiality of medical records, notify the payer regarding a change in circumstances such as licensure, hospital privileges, or DEA, in addition to standard contract boiler-plate provisions pertaining to notice, waiver of breach, and the like.

More variable

There are another range of typical provisions that tend to be more variable. These include whether participation is for all product lines of the payer (e.g. Medicare Advantage as well as commercial; HMO as well as PPO) or whether the physicians may pick and choose among product lines. This may be specified in the document, or incorporated in exhibits. Where the Blue Cross Association plans are concerned, the obligation to serve people insured by an out-of-state plan will be addressed. Typically contracts vary as to whether they are with a group or an individual. When they are with a group, what happens with a non-compliant physician within the group will be addressed.

What are considered covered services can be handled variably as well. For example, they may be enumerated on an exhibit, set forth in a manual, or listed on a website. By contrast, "non-covered services" may be anything that is not specifically covered, or only those services defined as non-covered and therefore eligible to be charged to the patient. On the issues of physician availability and accessibility, some agreements specify a minimum number of office hours. Some merely say

Key takeaways

- **It is important for dermatologists to understand the provisions of their payer contracts, though those in larger groups may have little say in negotiating them.**
- **Typical contract provisions address whether a physician participates in all or some of a payer's insurance products, what services are covered, and how the contract may be terminated.**
- **Recent contracts often address quality bonuses and performance withholds, bundling of payments for multiple providers, and episode-of-care payments.**
- **Some new contracts also address the sources of data to be used in measuring provider performance.**

24-hour coverage must be available. Some require a specific appointment response time (e.g. physician shall see non-urgent patients within three days of a patient request). Most address the fact that covering physicians may only be those that participate with the same payer, but some say if a non-participating physician covers, the participating physician is responsible for his compliance with the terms of the agreement. The use of ancillary personnel may remain completely unaddressed, or be deferred to the legitimacy of using any ancillary personnel as authorized under state law. Some contracts specifically address the use of mid-level practitioners.

Termination clauses are critical. The agreement may offer termination without cause by either party after a defined notice period. Some offer without-cause termination by the plan on a specified number of days' notice, but by the physician only after a year in the network. The payers do not like to have to re-contract the network, so once physicians are participating, some agreements bind them to participate for a specified period of time. Some permit without-cause termination by the physician only at a specified annual renewal date before automatic renewal. Most specify termination with cause, offering an opportunity to cure for some causes. Other agreements set forth especially egregious bases for termination immediately upon notice with no opportunity to cure. Some provide for appeals. Many do not.

Agreements vary with regard to how they approach the issue of amendments. Some say amendments may only be as mutually agreed. Some say the payer may unilaterally amend if required by statute or regulation. Others say the payer may unilaterally amend the agreement, giving the provider an opportunity to object which then gives the plan a right to terminate because of the objection. Some say the payer can amend unilaterally, deeming that the provider has accepted the change if the provider accepts any money after the notice of the amendment. Some say that the payer may unilaterally amend, unless the provider objects, in which case the agreement goes on as originally drafted.

The new environment

The new environment for contracting is so competitive that certain competition issues may be addressed in the participation agreement. The physicians may be required to notify the payer of any merger with or acquisition of another practice. Some payers specifically take the position that the rates they have negotiated are not available if the group merges or experiences a change of control. Some plans also include anti-referral provisions that require physicians to notify the plan if they are introducing new ancillary services or are referring patients to ancillary services with which they have financial relationships. For dermatologists, this may implicate dermatopathology relationships.

Many plans include business confidentiality provisions which restrict the ability of the physicians to share any information regarding rates or other items deemed confidential by the plan. In the mid-'90s many plans included anti-disparagement clauses restricting the ability of the physician to criticize the plan. Many of the state regulations that were adopted during that period of time prohibit such provisions, often referred to as "gag clauses." Today it can be expected that there will be a provision that states explicitly that the physician is able to discuss any treatment with the patient using his best medical judgment.

The most significant new provisions, however, pertain to (1) new payment models, including quality bonuses and (2) a significantly stronger emphasis on data.

1. New compensation models

The simplest forms of new compensation models are quality bonuses or performance withholds. The critical issue here is to make sure the rules of the game are explicitly stated in the contract or an exhibit prior to entering into the agreement. In the quality realm, some models pay bonuses for absolute performance (e.g. if the target is met the bonus is paid). Some pay for demonstrated process improvement (e.g. we pay $X if your process improves 25 percent over the baseline and $Y if it improves 50 percent). Others pay on a comparative basis ranked against

the rest of the performance "class", so to speak (e.g. we pay bonuses to the top 2 percent of performers). Issues here are agreement on the quality measures, whether they can be changed over time, and what happens if there is a dispute about either the calculation of the bonus based on the performance or the data upon which it is based. The obverse is a penalty for failure to perform. Here the issues are what triggers the penalty, (e.g. a single failure or a pattern of underperformance) which is typically expressed as a withhold, but may also be a rate reduction. The data that determines the application of the penalty is similarly important. How long the penalty is in place and how it can be lifted are issues to be addressed, along with handling disputes over the data which forms the basis for the penalty.

Among the new payment models are bundled payments which combine at least two separate providers into a single budget. Often these are physicians with hospitals but they can also be horizontal along a continuum of care among disparate physicians treating patients along with ancillary services (e.g. dermatologists with laboratories). One of the key issues in bundled payment arrangements is who holds the money and distributes it, or whether the budget can be allocated separately as it can in the PROMETHEUS Payment® model (www.HCI3.org). While in a very few instances bundled payments are made prospectively, most bundled payment models turn on paying physicians and other providers in the ordinary course, and then having them share in the savings that are generated by their more efficient performance. Some contracts state a threshold of quality performance which must be met before the gainsharing is available.

Episode payments are a fixed payment for the treatment of a defined diagnosis or treatment over a defined timeframe. They can be used in chronic care where the episode is an annual period to coincide with the premium year or an episode can be for a hospitalization and all the ensuing related services. Similarly, a defined diagnosis can be the foundation for an episode (e.g. initial treatment for Stage 1 breast cancer). Traditionally prenatal care and delivery have been subject to episode payments. What triggers and what breaks the episode, as well as a clear definition of when it expires, are important terms.

Some people believe that patient-centered medical homes, specialty patient-centered medical homes ("medical neighborhoods"), or ACOs are payment models. They are not. They are groups of providers or networks which are measured together. They may deploy any of the new forms of payment or, more typically, in taking more risk, the entity will be paid a percent of premium with some other payment model being used by the network with its participating physicians. Capitation is also still used but mostly for primary care. Similarly, as in the Medicare Oncology Payment Model, sometimes additional payments are made to physicians for managing the patient's care.

2. Data

One of the major differences between the modern payer contract and those from before is the emphasis on how data is used: to include physicians in networks and exclude others, to measure performance, to apply bonuses, to report providers in grading systems, and otherwise. Specifying in the contract the source of data to be used for any of these purposes is important. In what form and format the data must be provided (e.g. electronic, paper, specified data fields) should be stated. Whether any compensation will be made to the provider for providing data is relevant. How often the data is reported is critical. The extent to which the payer has the right to come in and itself gather data from the physician practice is also an issue. Who will own the applicable data is important as well, since in today's market, data has commercial value. Having access to any reports that include the practice's data, as well as the process for challenging inaccuracies, should be addressed.

Conclusion

Whether any practice will have the ability to negotiate terms with a payer will depend on a multiplicity of factors. Still, the content of the contracts will affect significant aspects of the practice. Review by a knowledgeable attorney before signing is useful and may be very important in the face of the modern payer contract. ***dw***