Negotiating Managed Care Contracts

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All too often, physicians sign a managed care contract (“MCC”) without so much as reading it. Many of those who bother to open it simply glance at the reimbursement exhibit, confident that everything else is simply “boilerplate”. Nothing could be farther from the truth. While the terms of the MCC determine how much a physician will be paid for his or her efforts\(^1\), they also have a major impact on:

- who he must treat,
- when he must treat them,
- for how long he must treat them,
- what services he will be paid for,
- what he must do to be paid,
- how timely he will be paid,
- how dependably he will be paid,
- when he can be certain that his receipts will not be recouped by the payer,
- how stable his relationship with the payer will be,
- how many payer intrusions he must endure,
- how many administrative people he must employ,
- how pleasant his day-to-day life will be, and last, but certainly not least,
- his reputation within the patient, provider and employer communities.

Successful negotiation of MCCs requires that the physician first recognize these impacts and second, commit to taking the steps necessary to address them.

I. PREPARING FOR NEGOTIATIONS

As with most of life’s challenges, a great deal of success is born of preparation. Hence, the **Number One Rule of Negotiations: Never enter unprepared.** The first step in preparing is knowing why you are contracting. This threshold issue often is skipped entirely: “Of course, I must contract with Health Plan X.” Are you sure? Do you really need a contract with the plan or merely want one? Many physicians assume that they must have a contract with every plan in town. “If I don’t, I’ll get left behind.” A retrospective analysis of each plan with which you contract – something that should be performed at least annually – may disclose that the plan in question not only is not profitable, but also is responsible for a disproportionate share of your administrative hassles and expense.

The answer to Want-or-Need? largely will determine your approach to negotiations. You must be willing to put more effort and expense into the contract you truly need than one that

\(^1\) While many of the author’s favorite physician clients are female, for the sake of brevity all future references will use only the masculine noun or adjective.
merely would be nice to have. With the latter, you can simply walk away if things don’t go your way or the plan is unwilling to satisfy your requests.

Far too often, physicians simply assume that the MCC is “non-negotiable”, that they have no bargaining power, and that requesting changes is simply a “waste of time”. Which brings us to the Second Rule of Negotiations: The plan may not agree to everything you want, but it definitely will not agree if you do not make the request. Physicians don’t become physicians if they fear failure. Take the same approach in your business dealings with health plans. Don’t be afraid to appear greedy or needy or unreasonable; this is business.

To plan your negotiation strategy, you must know yourself. You must critically and honestly assess your:

- strengths,
- weaknesses,
- place in the market,
- competition,
- current and desired payer mix, and
- tolerance for risk, both financial and reputational.

Are the members of your practice each 20+ years out of residency and the only pediatric neurosurgeons within fifty miles, or struggling family practitioners fresh out of residency? Can you financially and emotionally handle the risks and uncertainty of full capitation? Do you really need more Medicaid patients? Will that additional PPO plan materially benefit your practice?

Equally important, you must know the plan/payer. Don’t simply assume that the plan is the “great and almighty wizard”; take the time to carefully must assess its:

- strengths,
- weaknesses,
- market penetration,
- network strength,
- current financial status and performance, and
- competition.

The plan may be a heavy-weight nationally, but how many members/enrollees does it actually have in your local area? Do you feel a niche that they need to pass network-adequacy requirements? Have they made the industry news lately for their recent record profits, or are they teetering on the edge of insolvency and receivership? Finally, consider the impact that contracting with the plan will have on other plans in your area. It might be beneficial in the long run to take a fee reduction with the new plan in town in order to help develop competition for the local 800-pound gorilla.

You wouldn’t commence surgery without a surgical plan, including a “plan B” in case complications develop. Contract negotiation requires the same advance consideration of your goals and alternatives. This is where the wants vs. needs analysis really comes into play. While you may want changes on ten or twenty issues, clearly they won’t all be of equal importance to
you. Know in advance how they rank. **Third Rule of Negotiations: Never begin negotiations without first being certain of both (a) your initial positions and (b) your ultimate “lines in the sand”**. If you don’t know both, postpone the negotiation until you do. Kenny Rogers had it right: “know when to hold and when to fold.” You must be prepared to either walk away or concede and know when you will do so. Remember, a bad contract with a great health plan is still a bad contract.

**Kopson’s Corollary to the Third Rule of Negotiations: Learn to say “No” both emphatically and repeatedly; once is not enough.** It is amazing how conflict adverse and polite physicians can be. As a result, they often are hesitant to say “no” to wholly unreasonable plan demands. More importantly and more detrimentally, even after an initial refusal, physicians very commonly capitulate and say “ok” when the plan simply repeats the same unreasonable demand, either in the same words or merely restated. The physician must be committed to a firm stance. It often can take five, ten or even more times saying “No” before the plan will drop its demand or adopt a more reasonable compromise!

Negotiations and preparation are team sports; form your team strategically. Its composition should be driven by the goals you hope to achieve and the party on the other side of the table – this is where gathering intelligence on the plan must occur and where its benefits will show. Never conduct a negotiation without adequate input from your finance and operations personnel. They know where the problems are: slow-pays, difficulties obtaining authorizations, multiple requests for records and claim details, etc. If one of your people has a good relationship with the plan reps or a higher level plan employee, consider using them, either at the table or behind the scenes.

To use an attorney or not? This question must be resolved based on all of the facts including the importance of the contract, the percentage of your book of business it represents, how difficult the plan is to deal with and a variety of other situation-specific facts. I have found that I have far greater health success when I leave the diagnosing and treatment to my physician; I recognize my sphere of competence and stay within it. While nobody likes to pay attorneys (even other attorneys), the money spent up front to obtain a good contract can be dwarfed by the increased profits it produces or by the legal costs of trying to resolve problems that might have been avoided with the help of competent counsel. When making a decision on legal counsel, keep in mind that attorneys, like physicians, specialize. Use a health care attorney with managed care expertise. Their rates will be higher but they will be more efficient and are more likely to achieve better results.

**Fourth Rule of Negotiations: Your team must always speak with a single voice; never “argue in front of the kids.”** This rule applies regardless of whether your team does or does not include an attorney. “Divide And Conquer” is the single most common and most effective plan negotiating tactic. Determine who will speak for your team and abide by that decision. If a team member has a concern about the progress of negotiations or a statement made or tactic taken by the team’s spokesperson, call for a caucus; proceed into a separate room and develop a consensus on the concern before returning to the negotiating table. To facilitate this, always reserve at least two – and preferably three - rooms for conducting any major face-to-face negotiation.
II. CRITICAL ISSUES IN EVERY MCC

Regardless of the health plan in question, several critical issues must be addressed in every MCC. Addressing the fine points of these issues would require an entire book chapter for each of them. While compensation is of critical importance, the analysis and negotiation of the MCC cannot stop there and, in fact, should not start there. The reason is the Fifth Rule of Negotiations: All terms of the MCC impact financial performance! Most have heard the old saw “What the big print giveth, the fine print taketh away.” In the case of MCCs, “What the reimbursement exhibit giveth, virtually every other section of the contract can taketh away.” In view of this fact, each of the following issues should be considered in every MCC:

- What is covered?
- Definitions
- What constitutes the contract?
- Who can change the contract and how?
- What makes services payable?
- Term
- Termination
- Post-Termination Obligations
- Compensation
- Performance and Quality
- Other Data Issues
- Audit and Recoupment
- Dispute Resolution

What is covered?

This question applies to the Payers, the Products and the Covered Services. Below are common “Gotchas” for each:

Payer Gotcha: This Agreement is made by and between Physician, for itself and its affiliates.” Result: a very loud “Silent PPO”. Solutions: (a) Specify the Payers to which the MCC will apply. (b) Expressly prohibit assignment, sale or extension of the MCC’s rates to any other entity/ except by formal written agreement of the MCC.

Product Gotchas:

i) HMO terms, i.e., member hold-harmless provisions, extended to PPO product. Solution: Specify that the member hold-harmless provisions apply to only HMO products and/or only where such terms are mandated by applicable law.

ii) Data-production requirements and financial risk vastly different than anticipated. Solutions: (a) Specify all of the products to which the MCC applies and prohibit changes except by formal


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written agreement of the MCC. (b) Use a separate compensation exhibit for each product covered by the Agreement.

iii) Every Physician in Physician Group must participate in all products listed on the Products Appendix – Result: Dr. Smith, one your group’s most profitable physicians, leaves the group because he refuses to participate in Medicaid. **Solutions:** (a) Provide for specific product-by-product opt-out. (b) Specify exception to all-physicians clause so long as access mandates are satisfied.

**Covered Services Gotcha:** “Covered Services means those services deemed covered by the enrollees health benefit plan. **Solution:** Define Covered Services as all Medically Necessary services other than those specified on Appendix X.”

**Definitions**

Definitions are simultaneously the least sexy and most important provisions in the MCC. Without carefully reviewed and revised defined terms, the contract may mean something entirely different than you anticipated. Some of the most important terms to define are: “Plan”, “Payer”, “Enrollee”/“Member”/“Beneficiary”/“Insured”, “Medically Necessary”, and “Clean Claim.”

**“Plan” vs. “Payer” Gotcha:** “MegaHealth PPO does not pay claims and has no responsibility for Payer’s payment or nonpayment” Result: Physician may have no direct contract or contractual privity with the actual Payer and may be left with an uphill battle in the event of its unjustified nonpayment. **Solutions:** (a) Carefully define “Payer” as the entity responsible for paying and which agrees to pay Physician for Covered Services. (b) Specify that Physician is an intended third-party beneficiary of the PPO’s contract with the Plan/Payer. (c) Obligate the PPO to require the Plan/Payer to comply with the payment obligations specified in the MCC.

**Enrollee Gotcha:** The MCC rates are extended to individuals with 100% copay, 100% self-pay or discount card programs not intended by Physician and which lack contractual privity and/or financial stability and who might otherwise be responsible for the physician’s full charge or entitled to smaller discount. **Solution:** Expressly carve out from “Enrollee” definition individuals with 100% copay, 100% self-pay or discount card programs

**Medically Necessary Gotcha:** “medically necessary as determined by Plan or Plan’s Medical Director.” Result: Different opinion = Different financial result. **Solution:** Define Medically Necessary by reference to the standard of care within the local community and specify that the treating physician’s judgment governs or, at least, is presumed correct subject to rebuttal.

**Clean Claim Gotcha:** Failure to define gives the Plan multiple bites of the claim-denial “apple” resulting in lost time value of the payment and additional administrative expense. **Solution:** Specify, in detail, what constitutes a Clean Claim; that the Plan has a single opportunity to request additional information within a specified time; and that failure to request within that period means the claim is deemed to be a Clean Claim.
What constitutes the contract?

Physicians and attorneys alike often are surprised to learn that MCC document in their hand is not “the contract” or is subject to being superseded in whole or in part (including the most critically important parts) by one or more other documents that are subject to unilateral drafting and revision by the Plan! Today, it is increasingly common to find that the MCC incorporates by reference some or all of the following: “all of the Plan’s policies and procedures”, the Provider Manual, multiple exhibits, addenda and appendices, the Plan’s UM/QM Program, the Plan’s pay for performance program, multiple external accreditation criteria and accrediting entity policies, and/or Medicare and Medicare policies. Together, these external elements of MCC, beyond the Physician’s control and subject to unilateral modification for the single biggest Gotcha today: the Illusory Contract.

Gotcha: “the Agreement is comprised of this document and Plans policies and procedures, including but not limited to…” Solutions: (a) specify that the policies and procedures applicable to the Agreement are only those in effect as of the Effective Date that have been furnished top Physician in advance. (b) Include a Hierarchy of Provisions, that specifies which provisions supersede and govern in the event and to the extent of a conflict, e.g., between the contract instrument itself and any exhibit or addendum or between the Agreement and any Plan policy or procedure. (c) Specify that any Plan policy or procedure contrary to or inconsistent with the Agreement does not apply to Physician during the term of the Agreement. (Caveat: This latter tactic likely is insufficient if the Plan’s policies and procedures are “incorporated by reference into the Agreement.)

Who can change the contract and how?

This issue is closely related to the preceding issue but relates more to the specific procedures. If the Plan is permitted to adopt policies that modify the Agreement, limitations should be specified.

Gotcha: “Death by a thousand cuts.” Solution: Specify limits as to which Plan policies will be permitted to modify the Agreement and when/how frequently and a detailed notice and objection process.

Gotcha: “Plan shall give Physician notice of [policy changes] or [modifications to this Agreement] by written notice or publication on Plan’s website.” (We all know that every physician employs an entire host of people who do nothing all day but review the entire website of every plan with which the physician participates to make note of any changes, right?) Solutions: (a) Mandate that notice of material changes be given only by US mail or overnight delivery (b) Expressly prohibit notice of such changes by website posting, email or fax.

What makes services payable?

Merely specifying which services are Covered Services does not address the substantive and procedural hurdles that must be overcome to obtain payment for them. The issues that must be addressed in this regard include medical necessity, prior authorization, eligibility, claims format, and time for submission of claims. Some of the common Gotchas for these issues have been covered elsewhere above, e.g., defining Medical Necessity and Clean Claims.
Prior Authorization Gotcha: "Some services require prior authorization by Plan." Solution: Unless the physician is skilled in telepathic communication, it is best to specify, perhaps on an exhibit, all services that require prior authorization.

Prior Authorization Gotcha: Physician personnel cannot timely obtain prior authorization. Solution: (a) Provide that unless Plan denies prior authorization within a specified period, the service automatically will be deemed authorized. (b) Require that authorizations can be requested via web portal rather than only by telephone.

Prior Authorization Gotcha: Technical denials, e.g., Physician failed to obtain prior authorization but the facts are such that if requested, the service would have been authorized. Solution: "No harm, no foul." Expressly specify that if authorization would have been granted, failure to obtain it does not preclude payment or recoupment.

Eligibility Gotcha: Plan confirms eligibility but subsequently seeks recoupment of payment based on the fact that on the date of service, the patient in reality was not eligible. Solutions: (a) “If Plan confirms eligibility prior to Physician furnishing services to the Enrollee, then Plan cannot subsequently recoup payment for Covered Services if the Enrollee was not, in fact, eligible on the date the Covered Services were furnished.” (b) “If Plan confirms eligibility prior to Provider furnishing services to the Enrollee, but the Enrollee, was not, in fact, eligible on the date the Covered Services were furnished, Plan shall pay Physician one half (1/2) of the amount otherwise payable for such Covered Services.” (c) “Plan shall not retroactively deny payment or reimbursement or otherwise penalize Physician for failure to obtain confirmation of an Enrollee’s eligibility if such Enrollee is or was at the applicable time, in fact, eligible for Covered Services.”

Claim Submission Gotcha: Payer has secondary payment liability and the primary payer didn’t pay until after the deadline for claim submission. Solutions: (a) Specify a realistic deadline for claims submission. (b) “shall submit claims within 355 days after the date of service or, in cases where Payer has secondary payment liability, within 355 days after the date upon which Physician receives an explanation of payment from the primary payer.”

Term

Sixth Rule of Negotiations: Plan your exit before you enter. An important part of such planning is determining the length of the term of the MCC. Remember that this cuts both ways as it impacts how long both you and the Plan are bound to the MCC. A specified term provides certainty and may be desirable when contracting with an unknown Plan. However, it ensures that additional, affirmative contracting work will be required if you wish to continue after the end date. Conversely, an automatically renewing or “evergreen” contract may be more desirable when you know the Plan well, have hammered out virtually all details and have not had significant problems during prior contracts with the Plan. Evergreen may not be desirable in a very rapidly changing marketplace, as there likely will be a need for changes in several areas of the MCC within a year or two.

Evergreen Gotcha: Oops… too late; you’re stuck for another. Solutions: (a) Particularly if the termination provisions are onerous, e.g., permit termination only for cause or require a long period of advance notice, it is important to specify an adequate period of time within which to
give notice of non-renewal. (b) Deadlines for notice of non-renewal should be calendared and a specific individual charged with responsibility for monitoring such dates.

**Evergreen Gotcha:** The automatic renewal term will be subject to the same, potentially outdated or inadequate reimbursement provisions. **Solutions:** (a) Specify in advance a formula for automatic adjustment of reimbursement rates for renewal terms, e.g., COLA, specific percentage increase, etc. (Caveat: Determining such a change is increasingly difficult given the increasing speed of movement toward performance and outcomes based reimbursement.) (b) Specify a date, prior to the nonrenewal notice date, for mandatory negotiation of future reimbursement.

**Termination**

In addition to when, your exit strategy also must address how and on what bases you will be permitted to exit the MCC relationship. Without-cause termination gives you maximum flexibility, but the double-edged sword means you give up security and certainty for that flexibility. How much of a trade-off is desirable/acceptable. Under for-cause termination, the most important issue is what constitutes “cause”, followed closely by the period of notice required for termination and the opportunity, if any, to cure the “cause” or other alleged breach. At minimum, termination should be permitted only for a material breach; one-time or minor deficiencies, alone, should not permit termination.

**For-Cause Gotcha:** “Cause means any material breach or default *including but not limited to...*” **Solution:** Use a narrow, definition, e.g., “Cause” means only any one or more of the following events or occurrences…”

**For-Cause Gotcha:** “Cause means … or any conduct that exposes Plan to ridicule or reputational harm.” (Exactly what does that mean?) **Solution:** Define “Cause” using only objective criteria.

**For-Cause Gotcha:** “Cause means … any suspension of clinical or medical staff privileges.” Problem: Many medical staff bylaws impose automatic privileges suspensions if all medical records are not completed and signed within x days. **Solutions:** (a) Expressly carve out any automatic privileges suspensions based solely on untimely completion/signature of medical records. (b) When defining “Cause”, specify as grounds “only any suspension of clinical or medical staff privileges that is not fully revoked or terminated within thirty days”.

When the MCC will cover many products, it generally is desirable to permit the physician to terminate on a product-by-product basis. Thus, e.g., if there are repeated payment problems with the PPO product, the physician can terminate the MCC as to only the PPO product, without terminating it as to the HMO and Medicare products it also covers. As a general rule, the “nuclear option”, i.e., complete termination of the entire MCC is an illusory or, at best, poor remedy, particularly for a major contract covering a large percentage of the physician’s book of business.

The MCC should always require that written notice of breach or termination be given to specific person/title, e.g., the CEO or Director of Contracting. The plan should be required to also give these types of notice’s to the physician’s/group’s legal counsel. Given their importance, consider requiring that notices of breach, termination or non-renewal be given only by Certified
Mail, return-receipt requested or by next-day delivery via nationally operating courier, even if the MCC permits other types of notices to be given by regular mail or by (shudder) fax or email.

The physician should strive to have an opportunity to cure any breach or other basis for termination. While Plans typically will insist that some events permit “immediate termination”, efforts should be made to severely limit the events that permit termination without a cure opportunity (e.g., loss of medical license, exclusion from Medicare/Medicaid, etc.). Moreover, termination for even these occurrences should be “effective immediately upon written notice to Physician”. Permitting immediate termination without notice poses a variety of problematic issues and unnecessary potential liability exposure.

Finally, consider whether other events should permit the physician to terminate the MCC, e.g., notice of objectionable change of Plan policy, a downward adjustment of reimbursement or payment penalty, or an objectionable assignment by the Plan or change in its ownership or control.

**Post-Termination Obligations**

The only thing worse than having to terminate a bad contract is discovering that you “can’t escape it” due to onerous post-termination treatment obligations. Hence, it is important to know the state and federal legal post-termination treatment requirements applicable to the products to which the MCC applies.

**Post-Termination Gotcha:** “shall continue treating Enrollees in accordance with this Agreement under all Enrollees are reassigned by Plan to other Participating Provider” **Solution:** Specify a finite date for the end of post-termination treatment obligations, subject to applicable laws.

**Post-Termination Gotcha:** “The Contract Rates shall apply to all post-termination services furnished by Physician.” **Solution:** If the MCC provides for a significant discount from the Physician’s normal charges, specify a finite date after which post-termination treatment will be reimbursed at either the Physician’s normal charges or a multiple of the original contract rate.

**Post-Termination Gotcha – The endless Loop:** “Physician shall continue to comply with the terms of this Agreement after the date of termination or expiration.” (Terminate means terminate, doesn’t it?)

**Compensation: How and what am I paid?**

Major questions regarding compensation include: (i) What is the payment mechanism? (ii) Is it subject to change and, if so, how and when? (iii) Is compensation subject to reduction as a penalty and, if so, on what bases and for how long? (iv) Are there multiple compensation tiers (or multiple member-responsibility tiers) and, if so, what tier will you be in, when and on what bases will that be subject to change, and what due process or appeal rights will you have?
Common compensation “Gotchas” include:

**Fee-for-Service Gotcha:** “Physician will be paid in accordance with the *MegaHealth Plan Physician Fee Schedule.*” What is that? **Solution:** Specify the fee schedule as, e.g., “105% of the Medicare Physician Fee Schedule.”

**Capitation Gotcha:** “if cost of care exceeds budget, then...” How are costs calculated? **Solution:** Define “costs” and their calculation in detail. Consider using examples to enhance clarity.

**Capitation Gotcha:** Risk pools will be reconciled annually with an *IBNR estimate.*” **Solutions:** (a) Provide for reconciliation a sufficient time after the contract year to obviate the need for an IBNR estimate. (b) Provide for a second, final reconciliation, based on only actual claims payments, twelve months after the initial annual reconciliation.

**Bundled Payment Gotcha:** Specific services carved out for performance by physicians *outside of your group.* **Solutions:** (a) Specify that services may be furnished only by your group’s physicians (b) Separately contract in advance with the carve-out physicians regarding reconciliation payments in the event of extraordinary cost performance.

**The Ultimate Compensation Gotcha:** Plan has the ability to unilaterally change compensation. (Aren’t you glad you spent so much time negotiating a great Fee Schedule?) Examples: “The Physician Fee Schedule is subject periodic change by Plan with thirty days’ notice to Physician” or “in the event of federal sequestration” or “in accordance with Plan’s standard adjustment process” or **Solutions:** (a) Specifically preclude any downward change in compensation except by formal written amendment of the MCC. (b) If FFS compensation is tied to Medicare Physician Fee Schedule, specify that changes can be made only to exactly match CMS changes and that they must be made within, e.g., not more than 30 days after CMS’ publication of the change.

**Performance and Quality**

The accelerating trend toward performance and outcomes based reimbursement and relative performance rankings underscores the **Seventh Rule of Negotiations: The devil is in the details!** In all such arrangements the MCC should specify in detail: (a) What is being measured (b) the performance measures, (c) the specific benchmarks and metrics that will be applied, and (d) what is being rewarded (i.e., raw score alone vs. improvement over prior results).

**Performance and Quality Gotcha:** Changing the rules mid-game. Imagine advancing the football ten yards on fourth down to first and goal in the Big Game, only to be told that first downs now require advancing fifteen yards! **Solution:** Specify all of the critical details of the performance/quality mechanism in advance and prohibit any changes mid-contract except by mutual written agreement/formal amendment. Example:

The quality measure definitions and data collection parameters for the MegaHealth Quality Performance Program (MQPP), including the specific patient population to which each measure applies and
the specific data that will be considered in determining Provider Group’s performance on each measure, are set forth in the MQPP Manual, attached hereto as Appendix Q. The MQPP Manual shall remain in place and unchanged for Physician Group for the entire 2016 contract year except as Plan and Physician Provider otherwise expressly mutually agree in writing, regardless of any change made to the MQPP Manual or any other manual or document on Plan’s website.

Other critical issues to address include: (a) What is the population being measured, i.e., the denominator (e.g., all Plan patients, all of Physician’s patients, etc.) and what impact will changes have (e.g., a patient moves mid-year)? (b) At what provider level is it being measured (e.g., individual physician, entire physician practice, entire IPA/PO, etc.) what and what impact will changes have (e.g., a new physician joins the practice mid-year)? (c) What data sources are considered (e.g., claims data only, all physician chart data, external records)? (d) What, if any, processes will exist for the physician to review or validate the raw data and calculations used to score him?

Given what is at stake – not only the physician’s revenue, but also his reputation – it is critically important to negotiate adequate challenge and appeal procedures. Standard dispute resolution mechanisms, such as plain vanilla arbitration, likely are inadequate in terms of both speed and remedy. Particularly when the data is to be widely published, timing is critical. If the negative data is published before dispute is resolved, it may be nearly impossible to un-ring the bell. Pre-publication resolution is therefore imperative.

The MCC should specify the mechanism for resolving quality/performance data disputes, including both internal mechanisms and any right to independent third-party review, something clearly desirable from the physician’s perspective. Any requirement for exhaustion of internal procedures should be specified. As noted above, the remedies provisions should be heavily negotiated, with consideration given to both money damages and equitable relief (e.g., broad publication of retraction or correction). Consider the benefit of a loser-pays attorney fees provisions. This serves both parties as it both evens the playing field for the shallower-pocketed physician and serves as a deterrent to meritless objections or appeals. Finally, the MCC should address the impact of any appeal process on payments, e.g., during the pendency of the appeal will sums not in dispute be distributed or will the entire annual reconciliation and associated payments be put on hold? If placed on hold, will interest be paid on any sum eventually ruled payable to the physician?

Other Data Issues

Whether for reimbursement or marketing purposes, satisfaction of accreditation requirements or the development of best practices and outcome patterns, plans are requiring that Physicians provide ever-increasing amounts and types of data. This data can extend well beyond quality and outcomes statistics and typical claims and encounter data. In order to avoid inappropriate demands and unnecessary expense and administrative burdens, physicians should ensure that the MCC specifies (a) what specific type of data are required, (b) the specific format(s) in which it must be produced, (c) how frequently regular data must be provided, (d) how frequently special data or ad hoc reports may be required, (e) who is responsible for the cost
of providing the required data in the required formats (and whether that varies based upon the type or frequency of the request or the required format), (f) who will own each type of data or be granted a license for its use and the terms of each such license, including whether it is exclusive or non-exclusive, (g) the uses to which data may be put, (h) relative responsibilities for maintaining confidentiality of data, including the extension of confidentiality obligations to subcontractors (e.g., auditors) and downstream entities, (i) whether privileges will exempt some data (e.g., peer-review reports or attorney-client communications) from production and how they will be preserved and, finally, (j) the parties’ respective obligations under HIPAA and HITECH and with regard to any breach or violation of those obligations, including any indemnification obligations.

Audit and Recoupment

In today’s managed care world, every expense is scrutinized with a fine-tooth comb and Plans are ratcheting up their audit and recovery or recoupment efforts. To ensure that the physician not only receives every payment that he earns but also retains it, the MCC should address audit and recoupment in detail. Specific issues to be addressed include: (a) the applicable criteria under which claims and payments will be reviewed, (b) the maximum look-back period or statute of limitations after which the parties can no longer pursue correction of underpayments or overpayments, (c) how much, and how detailed, notice must the physician be given in advance of an audit (d) how frequently can audits be conducted and how many records can be requested or reviewed each time, (e) confidentiality obligations of audit-performance personnel and contractors, (f) who will perform the audits, and (g) the nature and specificity of findings that must be shared with the physician, both in an exit interview and in a final report to the physician.

With respect to the financial impact of the audit, the MCC also should specify: (a) statistical sampling requirements and whether errors or error rates can be extrapolated to the entire universe of claims and payment during the period covered by the audit sample, (b) mechanisms and procedures for validating the Plan’s sampling, extrapolation and recoupment calculations, (c) the physician’s due process and appeal rights and procedures for challenging the audit findings and associated recoupment demands, (d) whether the physician, at any point, has a right to review by an independent third-party expert (Appeal procedures that both start and end with the Plan don’t typically go well for the physician.), and (e) the parties’ relative liability for the costs of the audit and of resolution of any resulting disputes.

Audit Gotcha: During post-payment audit the Plan applies more stringent criteria, e.g., for Medical Necessity, than were applied during the Prior Authorization or Concurrent Review process(es). Solution: Specify that the Plan must apply the same criteria during any post-payment audit that is utilized in any Prior Authorization or Concurrent Review process(es).

3 In this regard, it should be noted that there may be no need for a Business Associate Agreement between the Physician and the Plan. One is not required for a health plan to share protected health information (without patient authorization but subject to the minimum necessary rule) with a physician (both Covered Entities) regarding their common enrollee/patient, if the PHI is shared for purposes of care management, credentialing and physician training, including quality improvement, or investigation of fraud and abuse. A Business Associate Agreement would be required only if the physician and plan wish to share PHI for other purposes or if third parties (e.g., administrative services subcontractors) are interjected between them.
Auditor Gotcha: $6,500 actual errors result in a $730,000 demand. **Solutions:** (a) When possible, preclude extrapolation of audit results, limiting recoveries to only claims actually reviewed. (b) When that is not possible, specify detailed requirements for sampling and extrapolation and a fair process for challenging both the substantive audit findings (on the services actually reviewed) and all extrapolations and calculations of the ultimate recoumpt demand.

**Audit Gotcha:** Following completion of the audit and recoupment demand, the Plan immediately begins offsetting the claimed overpayment against payments for subsequently furnished services. Result: Zero cash-flow effectively precludes a viable challenge of the audit findings. **Solution:** (a) Specify that no claimed overpayment can be offset against payments for subsequently furnished services during the pendency of either the entire appeal (preferable) or at least during the initial stage or stages of the appeal process. (b) Specify that the Plan must immediately pay all uncontested claims and claims subsequently decided in the physician’s favor.

**Dispute Resolution**

It is both unrealistic and inadvisable to assume that no dispute will arise during performance of a major contract involving a large number of variables and a large amount of money. Hence, every MCC should include carefully negotiated dispute resolution provisions. When considering these terms consider: (a) the terms and impact of any internal Plan dispute resolution mechanisms, including whether they are the exclusive mechanism for resolution (hopefully not) or whether the physician must merely first exhaust them before pursuing any external mechanism, and (b) whether your interests are better served by arbitration or court litigation.

If arbitration will be utilized, specify: (a) whether any contractual statute of limitations will limit the time within which arbitration must be demanded or deemed waived, (b) what entity/arbitration service must be used and what rules will apply (e.g., AHLA, AAA, JAMS), (c) how many arbitrators will be used, (d) whether and what type of discovery will be permitted and (e) how the costs of the arbitration, including filing fees, arbitrator fees, and any service administrative fees will be allocated and on what basis.

If court litigation will be utilized, specify: (a) whether any contractual statute of limitations will limit the time within which suit must be filed or deemed waived, (b) what court(s) will have jurisdiction, (c) where venue will be proper, (d) whether trial will be by jury or to a judge, and (e) whether the successful party may recover its litigation costs and attorney fees and any associated limitations.

**Arbitration Gotcha:** No class actions permitted. **Solution:** While the benefits of arbitration may be worth such a prohibition, attempt to negotiate away such limitations.

**Arbitration Gotcha:** “Plan’s internal Dispute Resolution Mechanism will be final for all claims not exceeding $50,000.” **Result:** The physician may effectively be precluded from pursuing any external resolution mechanism for virtually all disputes. **Solutions:** (a) Negotiate a minimum claim amount that realistically will permit external review and resolution of the majority of likely claims. (b) Specify that the physician’s claims may be aggregated to achieve the minimum amount required for pursuit of external resolution.
**Arbitration Gotcha:** The bad actor not be bound by the arbitration clause within MCC. **Solutions:** (a) a PPO/ASO MCC, specify that Physician is an intended third-party beneficiary of the PPO’s contract with the Payer. (b) Expressly obligate the PPO to require the Payer to comply with the payment obligations specified in the MCC. (c) Require that the actual Payer be a party to the MCC solely for purposes of (i) the payment obligations specified in the MCC and (ii) the MCC’s arbitration clause.

### III. CONTRACTING HYGIENE

Just as physicians develop and implement systems to achieve optimal medical outcomes, so too must they develop and implement procedures to maximize the benefit they derive from their MCCs and minimize the legal and financial exposure they pose. Basic managed care contracting hygiene is relatively simple and straightforward but all too often neglected. Every physician practice and physician contracting group or organization should:

- Assign internal contract review and maintenance responsibility to a specific individual or position within the practice/organization. Accountability breeds attention.

- Ensure that internal contract reviews are conducted on a regular schedule. At minimum, the database should include the following for each MCC:
  - parties
  - Effective Date
  - initial term end and renewal dates
  - any date by which a demand for renegotiation must be given
  - any date by which a notice of non-renewal must be given
  - a summary of the reimbursement/compensation methodology and the bases and timing of any change to the reimbursement/compensation
  - the means by which notices must be given and any variations based upon type of notice.

- All key dates should be carefully diaried, together with ticklers/reminders sufficiently in advance to permit internal discussion and necessary action on key dates.

- Schedule a regular time to address contracting issues (a) among office staff, (b) between office staff and the physician or physician leader(s), and (c) between the physician practice/organization and each Plan. Don’t let operational or payment problems rise to emergency or crisis level before addressing them.

- Maintain good working relationships with plans. While there is no doubt that the physicians’ interests are, in many cases, adverse to those of the Plan, the days of a purely “Us vs. Them” mentality are long gone. The relationship between physician and Plan is inescapably symbiotic. Cooperation and collaboration are absolutely necessary for the success of either. Regular communications, like those recommended above, are a major means by which to achieve these goals. Active participation in focus groups and medical director or other meetings between the Plan and providers also are advised. At worst, the physician will have a better idea of what the Plan is up to and what lies ahead.
• Stay abreast of developments within the healthcare industry. Know the players in your market, both those existing and those attempting to break in. Stay abreast of compensation trends and new and upcoming methodologies, including what is and is not working for whom and why.

Taking these simple steps will better enable you to follow the Rules of Negotiation and to consistently achieve better managed care contracts.
Appendix 1: PDF of Power Point
Negotiating Managed Care Contracts

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