Negotiation of a Managed Care Agreement

By Dennis Hursh, Hursh & Hursh, P.C.

Executive Summary

Even the largest managed care company is usually willing to negotiate its participating provider agreements to some extent. Amazingly, however, many physician practices sign the first draft that is presented to them. By doing so, they not only "leave money on the table", but they also permit administrative hassles for their staff to develop that could have been avoided with aggressive negotiation of all managed care agreements. The bigger the managed care company's share of the market, the more important it is to assure a reasonable agreement is reached. Physicians must aggressively protect their rights, through negotiation or risk continuing reductions in their income and increases in workload.

Practice Pointer #1: Have an experienced health-care attorney review the agreement

Managed care companies utilize experienced legal counsel to draft their agreements. It is unrealistic to assume that a physician, a practice administrator, or an attorney who does not focus on this area will understand both the legal ramifications and the practical issues presented by a managed care agreement.

> **Action Step:** Locate, consult with and retain an attorney experienced in reviewing and negotiating managed care agreements. The fees of such attorneys are likely to be recouped many times over through decreased staff time in dealing with administrative problems, and potentially increased compensation.

> **Tactical Tip:** The state or local county medical society may have recommendations. If not, talk to physician or office managers at practices who have utilized an experienced attorney for their input.

Practice Pointer #2: Require a verifiable fee schedule

Few physicians would sign an employment agreement in which they agreed to be paid "the salary schedule in effect from time to time". However, many practices sign managed care agreements where they agree to be paid “the fee schedule in effect from time to time”. The fee schedule should be either a specified dollar amount for specific CPT codes, or should utilize an objective methodology such as a percentage of Medicare

payments for a specified year. The fee schedule should have an automatic inflation adjustment, and should not be subject to unilateral amendment by the managed care company.

> **Action Step:** Make sure you understand exactly what you will be paid under the agreement. Your office manager should be able to audit payments from the managed care company easily to determine if you are being paid appropriately.

> **Tactical Tip:** Do not fall for the oldest trick in the book: increasing the proposed compensation from "100% of the then-current fee schedule" to "115% of the then-current fee schedule". Consider proposing a reasonable fee schedule to the managed care company to begin negotiations. If specific CPT codes appear to provide lower compensation than the ones provided by the company's competitors, make sure the company is aware of that discrepancy. Pay particular attention to the CPT codes most often used in your practice.

Practice Pointer #3: Make sure you will be paid for your work

Many managed care agreements provide that only services that are "medically necessary" will be covered. The definition of medical necessity can often be paraphrased as "whatever we (the health plan) determine it is".

> **Action Step:** Attempt to negotiate a definition that is based upon a "prudent physician" standard.

> **Tactical Tip:** At a minimum, require that the determination of medical necessity be made in a "good faith" or "reasonable" manner.

Practice Pointer #4: Make sure you know whom you are contracting with

Preferred Provider Organizations ("PPOs") are frequently among the best payors. However, the definition of "Payor" in PPO agreements is critical. Many plans define a "Payor" as "an individual, organization, firm or governmental entity, or self-insured account that has executed an agreement with the plan". This definition would allow the plan to "rent" its network in a manner that could be deemed a "silent PPO". Specifically, if a patient with insurance through a small regional company located far away from your practice becomes ill, and presents at your office, you would expect to receive your usual, customary and reasonable fees for this office visit. However, if the patient's health plan or third party administrator is able to obtain access to your practice's negotiated rates

with a local PPO, you will receive a greatly reduced discounted fee for seeing the patient. In short, a "silent PPO" has the effect of changing UCR payments to discounted fees.

> **Action Step:** To address this issue, the definition of "Payor" should very clearly state that the term relates solely to the plan, affiliated entities in the insurance company holding group, and self-funded employee benefit plans that use the plan only as a third party administrator. Make sure that the definition of "Payor" specifically provides that the discounts being negotiated will not be accessible to any party other than those described above.

> **Tactical Tip:** Some health plans are willing to provide a list of self-funded employers that have access to these discounts. It would be prudent to assure that such a list is given, and to check the list against explanations of benefits received, to assure that the discounts negotiated with the plan are not being "rented" to other parties.

Practice Pointer #5: Protect yourself against the "bad apple"

Most PPO agreements bring all "Payors" under the umbrella protection of the agreement. Therefore, even though you may be very pleased in general with payment and other terms of the plan contract, your practice might suddenly realize that it is not being paid with respect to enrollees of one employer. Frequently, your only option in this case is to claim a breach of the agreement by the plan, and either terminate the entire agreement or "grin and bear it". A better alternative would be to negotiate a provision in the agreement to the effect that both parties acknowledge that agreements are being made between the plan and employers, and that your practice is a third party beneficiary of these agreements. This clause should give you the right to sue directly any employer who is not paying for services, **without** terminating the rest of your PPO agreement.

> **Action Step:** You should obtain specific provisions to the effect that, if a given employer is in default of its obligations, then the PPO will provide your practice with a copy of its agreement with the employer and make a demand for payment to the employer on your behalf. In any event, it should be made clear that your obligation to treat enrollees of that particular employer will be released upon your notification to the plan that the employer is a deadbeat.

> **Tactical Tip:** Initially, propose a provision requiring the PPO to make a demand, and to provide that if payment is still not forthcoming within a reasonable period of time, then the PPO has two options: either pay the claims itself, or assign all its rights under the PPO/employer agreement to

you. This approach tends to force the PPO to objectively evaluate the risk of a "bad apple".

Practice Pointer #6: Learn from past problems

Many practices have a relatively small number of CPT codes that account for the majority of the practice's income. Often, at contract renewal, the biggest complaint by the practice will be that the plan treats a given CPT code unevenly. Typically, the relevant scientific literature supports a given treatment modality under specified conditions. However, plan patients presenting with these conditions are frequently denied payment for this modality based upon an alleged lack of medical necessity. It is not uncommon for some significant portion of patients presenting with these conditions not to be denied payment by the plan. Sometimes, every plan enrollee is initially denied payment, but, upon appeal, coverage is granted. Many health plans utilize proprietary software in their decision-making process. The licensing agreements with the software companies often prohibit wide-scale distribution outside of the plan. Accordingly, provider relations representatives will earnestly assure you that they cannot provide you with the decision-making criteria.

Action Step: The best outcome in situations such as this is to utilize the relevant scientific literature as an attachment to the agreement, specifically stating that a given modality is appropriate under the circumstances described in this exhibit. Another approach, somewhat more common, would be a simple statement attached to the agreement that a given modality will be approved under certain defined circumstances.

Tactical Tip: The licensing agreements of most decision-making software companies do allow sharing of specific criteria for a given CPT code to a physician disputing payment. Thus, although the plan is most likely prohibited from providing you the decision-making criteria for all CPT codes in your specialty, it is most likely **not** prohibited from sharing the decision-making criteria with respect to a given CPT code, particularly if you are currently disputing a decision made based upon that criterion. This is an extraordinarily difficult provision to negotiate, since the plan quite rightly will be concerned about treating enrollees with identical conditions differently, depending upon which practice treats them. However, to the extent that the plan's medical director can be involved, that individual is likely to want to assure uniform **correct** treatment (and treatment payment decisions) for all patients. Therefore, if the criteria are appropriate and generally recognized, the plan's medical director may become an ally in contract negotiations on this point.

Practice Pointer #7: What is good for the goose is good for the gander

Most managed care companies strictly limit the amount of time in which a practice may amend a claim – frequently to just 90 days after the service was rendered. However, few agreements place any limitation upon the period of time in which the plan can review a paid claim. Accordingly, practices have faced retroactive adjustments with respect to claims paid **six years** earlier. Although medical records may be maintained for the distant future, detailed financial records with respect to individual claims are not commonly retained for long periods. Accordingly, the practice is likely to be unable to efficiently contest any retroactive adjustment based upon services performed more than a year or two before the adjustment is claimed by the plan.

> **Action Step:** Most managed care companies are willing to place some outer limit (e.g., two to three years) on the period of time in which they may retroactively reduce previously paid claims.
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> **Tactical Tip:** First, propose a "good for the goose, good for the gander" reciprocal provision that allows retroactive claim reduction for the same period of time that the practice is given to submit claims. By tying these two concepts, you can often increase the time given to submit claims, while limiting the time the plan can retroactively reduce claims.

Practice Pointer #8: Aggressively limit the plan's right to offset money owed to the practice

Most managed care agreements provide that, should the plan determine that it has overpaid any money to the practice, then the plan may simply offset this money against money owed for services rendered. The problem with this approach is that if a major payor determines that it has overpaid a large dollar value of claims, cash flow to the practice can be seriously jeopardized. Even worse, the practice manager will not be aware of this impending cash crisis until it hits, as the first inkling will be receipt of an explanation of benefits that shows an amount owed for services, and reflects an offset. A major adjustment by a large payor could be financially ruinous to a practice.

> **Action Step:** To avoid this result, negotiate contract language that requires the plan to give your practice reasonable advance notice of a proposed adjustment, together with an opportunity to contest the adjustment.
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> **Tactical Tip:** A minimum of 60 days advance notice should be provided. This will allow your practice administrator sufficient time to determine the scope of the problem and the accuracy of the plan's calculations.

Practice Pointer #9: Maintain your leverage at termination

Many managed care agreements provide that the plan, alone, is responsible and authorized to notify enrollees that your practice no longer participates in the network. This provision has the effect of tying your hands if you get into a dispute with the plan and want to terminate your agreement. Most plans provide for a 90 day "without cause" termination. In the event of a serious dispute, you might wish to invoke this provision and provide a notice of termination. The patients of the practice can be the most effective advocates of the practice if this occurs. Moreover, your practice administrator will be placed in an extremely difficult position if your patients in a given plan are attempting to schedule appointments or procedures after the effective date of termination, and he or she is prohibited from informing the patient that the practice will no longer be participating in the patient's insurance plan after a given date.

> **Action Step:** Make sure that your practice has the ability to notify patients in the event of a termination (or the giving of notice of a future termination) of the agreement.
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> **Tactical Tip:** Termination of the agreement is the "atomic bomb" in your arsenal. Although this should be used only when absolutely necessary, sometimes it is the only way to get the attention of upper-level decision-makers of the plan.

Practice Pointer #10: Do not allow the agreement to continue while a dispute is pending

Many managed care agreements require the practice to continue in the network while a dispute is pending. This can have the effect of preventing you from escaping from a contract, even if the plan has breached the agreement. Working through the plan's internal grievance mechanisms, then proceeding to mandatory arbitration can take months or even years. This could be devastating to the practice if the plan is breaching its agreement.

> **Action Step:** Make sure that there is some reasonable limit (i.e., 120 days after the initial notice of a dispute) on the amount of time that you will be forced to continue to honor the agreement if you get into a dispute with the plan.
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> **Tactical Tip:** Termination of the agreement because of a breach by the managed care company is a vital right you must maintain. This right becomes meaningless if you are forced to remain in the agreement long after the plan has breached its obligations to you.

Practice Pointer #11: You must go your own way

It is natural for physicians to discuss managed care compensation with their colleagues in other practices. Do not do it! Antitrust law prohibits "actions in restraint of trade" among competitors. Two practices in the same specialty are considered to be competing for the business of managed care companies and their enrollees. Even though both practices are extremely busy, and may have no desire (or even ability) to see new patients, the law still views them as competitors. Accordingly, a discussion of fees or other material terms of managed care agreements with colleagues in your area risks legal prosecution.

> **Action Step:** Avoid the temptation to join forces with other practices in your area to obtain better fees.
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> **Tactical Tip:** Your best chance of obtaining a reasonable agreement comes from utilizing experienced legal counsel to scrutinize carefully **all** the provisions of the agreement. Focusing solely on fees or relying on other practices to determine what is reasonable would likely not lead to the best result, even if it were legal.

Conclusion

In today's challenging environment, physician practices have to be tough to survive. Effective negotiations with managed care companies can no longer focus solely on basics such as fee schedules. Every detail of each contract must be scrutinized, evaluated, and negotiated.

Additional Resources

Managed Care Contracting 401

Dennis G. Hursh, Physicians News Digest (2004)

A Silent PPO Primer

Dennis G. Hursh, Physicians News Digest (2006)

The Successful Physician Negotiator: How to Get What You Deserve, Babitsky, Mangraviti, SEAK, Inc. (1998)

Health Care & Antitrust Law: Principles and Practice, John J. Miles, West Group, Inc. (2000)

Influencing Third-Party Payers: A How-To-Guide for Physicians, Medical Societies and Group Practices, American Society of Internal Medicine (1993)

Model Managed Care Contract

American Medical Association (2003)

About the Author

Dennis Hursh is a principal in Hursh & Hursh, P.C., a Middletown, Pennsylvania law firm concentrating on representation of physicians and physician group practices. Dennis' practice is concentrated on healthcare contract drafting, negotiation and interpretation. He represents physicians in all areas of contracting and practice management, and is involved in the design, organization and representation of employer welfare benefit plans, physician organizations, preferred provider organizations, hospital-physician joint ventures, coordinated care organizations, insurers and third party administrators. He may be reached at (866) DOC-LAW1, or by email at Dennis@PaHealthLaw.com