Think You’ve Negotiated A Favorable Managed Care Provider Agreement?

Gil Weber, MBA
When reviewing a provider agreement, I don’t first turn to the reimbursement schedule. Rather, I look at the termination protocols to see how my client can get out of the deal if things should go wrong.

Many practices and ASCs sign managed care contracts that, for one reason or another, do not turn out well or, at a minimum, need some serious “tweaking.” For the last 15 years I’ve been asked to help fix problems that went unrecognized when the contract was signed.

Naturally, most administrators (and physicians) would consider reimbursement the top priority, and during contract negotiations it’s of course critical to protect those reimbursement terms. Yet when reviewing a provider agreement, I don’t first turn to the reimbursement schedule. Rather, I look at the termination protocols to see how my client can get out of the deal if things should go wrong. One of the most common reasons contracts go bad is that payers reserve the right to change the deal at any time by amending the contract and turning it into something quite different than originally negotiated and signed by the parties.

This article illustrates some of these danger points and shows you what you can do about them.

Unilateral Amendments
The most dangerous provision I see in managed care contracts is the one whereby the payer reserves the right to make unilateral changes in the middle of a contract term. Such changes, particularly reductions to the fee schedule, can have a profound adverse impact on the practice. At its sole discretion, the payer in effect turns the originally negotiated deal on its head.

In some instances the practice or ASC is offered an opportunity to object, and perhaps negotiate, before the change goes into effect. In others it’s a “slam-dunk.” The practice or ASC is stuck with the change and no recourse except to terminate the contract. Neither option is satisfactory.

Thus it is important to know what protections might be afforded by state law. You’ll need to check with an experienced attorney, for the laws vary widely state-to-state and even within a state depending on the type of plan and product line—as this example from California clearly demonstrates.

For Medi-Cal (California’s Medicaid) and “Healthy Families” program plans: Contracts that include provisions permitting unilateral material changes must provide the physician a minimum of 90 business days’ notice, give the physician the right to negotiate the change within 30 business days of receiving notice of the change, and give the physician the right to terminate the contract within the 90-business day notice. Amendments can take effect within 90 business days if the physician fails to negotiate or terminate the agreement with the health plan.

The Real Problem
Here’s the difficulty: The provider agreement will specify the contract term in years. But another section of the contract will contain a statement allowing the payer to amend any portion of the contract at the payer’s sole discretion by giving the provider advance written notice—typically 30 to 90 days. This means that the one-, two-, or three-year contract is, in reality, maybe only a 30-day contract that might run for the one, two, or three years as originally written and signed.

But the payer can decide to change the contract the day after it goes into effect. For example, the payment terms may originally have specified $X per RVU, or Y% of 2009 Medicare Allowable. Suppose you have analyzed the data and determined that the rates are OK. The physician signs the contract figuring it’s a pretty good deal, especially compared to the other contracts in your file drawer.

But then in the middle of the contract term the payer unilaterally decides to lower reimbursement. It sends a “Dear Doctor” letter, and a short time later that change goes into effect for the remaining months or years of the contract term. And you’re stuck.

Hidden in Plain Sight
Here is language typical of that found in many provider agreements:

Plan may amend this Agreement, standard Plan fee schedules and administrative rules, procedures, policies, or programs that affect Provider compensation and that affect healthcare service delivery at any time during the term of this Agreement by providing Provider ninety (90) days’ prior written notice, except if a shorter notice period is required to comply with changes in applicable law. Any such amendment shall be in writing and shall include an effective date.

For amendments that are not material adverse changes in the terms continued on page 60
of this Agreement, Plan can amend this Agreement by providing 30 days advance written notice to Provider.

Every ophthalmology administrator knows that payers are unlikely to raise reimbursements unilaterally mid-contract (especially as Medicare Allowable seems perpetually at risk for reductions), so the implications are obvious. Payers are reserving the right to unilaterally lower reimbursements at any time or to change the contract in other ways that could be quite unfavorable to your business.

Language of the sort quoted above flouts the fairness in the time-honored principle of written contracts that they can be changed only with the written agreement of both parties, in effect precluding unilateral changes forced by either party. If a payer refuses to remove such language, beware; it’s a clear and unambiguous indication that you’re at significant potential risk.

Changing a Deal in the “Real World”

In the “real world” of business, if two parties are concerned that future circumstances may change and materially affect the contract, they can at a later time either negotiate an appropriately worded written amendment resolving the situation to the satisfaction of the parties or, if the circumstances cannot be resolved by written amendment, one or both parties may terminate.

That’s how it should be in managed care. What are some possible solutions for defusing this time bomb of forced unilateral changes to your existing contract?

First, during negotiations it’s essential that you strike all language allowing the payer to impose unilateral mid-contract changes and insist instead that mid-contract changes will be effective only with the written consent of both parties. Payers won’t like that, of course, and will fight to protect their own interests.

Yet the danger of mid-contract unilateral change is so great as to be a potential deal-breaker.

To protect your interests, you might negotiate for language approximating the following (subject to attorney review and approval):

This Agreement constitutes the entire understanding between the parties relating to the subject matter of the Agreement. Except as may otherwise be provided herein, to be effective, any modification of this Agreement must be in writing and signed by both parties.

Suppose the payer says “No.” Suppose it insists on maintaining the right to make mid-term contractual changes, yet you consider the contract very important to your practice or ASC. Maybe the cataract reimbursement is exceptional and you’re thinking it’s crazy not to accept. What then?

In such a case you must try to limit the matters subject to unilateral change. For example, I’ve been successful negotiating a provision that lets the payer make changes but exempts the fee schedule from unilateral amendment during the contract term. At least that critical part of the contract was protected and fixed for a defined period.

Here’s sample language you might consider to bring this to fruition. Again, with review and approval of your attorney, you can present it to the payer for inclusion in the Provider Agreement.

Throughout the term of this Agreement, the fee schedule agreed upon herein by the parties shall remain in full force and effect and shall not be altered in any manner except upon written amendment signed by both parties.

More Possible Solutions

I have reviewed a number of contracts that offered alternative solutions to accepting a payer’s unilateral revision of contract provisions out of hand.

- Some contracts contained a provision for discussions before any payer-imposed amendment became effective. They did not require the payer to retract an amendment if no alternative understanding could be reached, but at least they provided an opportunity for negotiations and, possibly, “tweaks” rather than a de-facto slam-dunk.

- Others included a provision that allowed the physician or ASC the right to say “No” to any unacceptable change and to opt-out of the contract through an early and painless (without-cause) termination. For example, if the normal termination notice period is 90 or 120 days, then to deal with unacceptable amendments you could try to add language allowing “out” in 30 days, or 60 at most.

- Along with that you might ask for this: a provision that if an amendment is going into place and if the practice has elected to terminate rather than continue under the changed terms, those new terms should not apply to the practice during the “roll-out” period leading to termination. Language along the following lines might be appropriate for modeling your negotiations:

The change to the reimbursement schedule that is the subject of the Provider’s notice of rejection will not go into effect as to Provider during such notice period or thereafter if Provider elects to terminate under this provision.

An Important Exception

Please note one important exception to all this discussion about shielding one’s practice from unilateral amendments. Mandated changes
imposed by the state or feds (and sometimes by credentialing entities) will go into place automatically at the end of the notice period, and your practice cannot refuse such mandated change(s) if it is to continue in the contract.

That said, however, given the uncertainty of healthcare reform, there’s no predicting what mandates might emerge from Congress in the next few months or years.¹ You’ll want to try to secure an escape clause in the event a mandated change is so problematic that keeping the contract can’t be justified.

Language along these general lines is fair and balanced for all parties: 

In addition to the amendment provisions in this Section, the parties agree that if, after the effective date of this Agreement, a change in applicable law is enacted that requires changes to this Agreement that would deprive either party of an essential benefit of its bargain, either party may terminate this Agreement effective on the effective date of the change in applicable law.

A Final Concern

Provider Agreements typically differentiate material changes or modifications from non-material ones. Material changes might include modification of the fee schedule, the Provider Manual, or Administrative Guidelines. Non-material changes could be absolutely anything.

The contract might stipulate that the payer must give a certain number of days’ advance written notice of material changes, but not require any advance notice of non-material changes. That immediately creates two issues: (1) what differentiates material from non-material changes, and (2) who decides what’s material?

Some but not all state managed care laws provide guidance here. If yours does not, it’s left to each payer to decide what is and is not material. In its infinite wisdom, a payer could deem an issue non-material while that same issue could be very material to your practice or ASC.

Thus it’s important to know how or if state law applies here. If it does not, then it’s essential to arrive at an understanding with the payer over what constitutes a material change requiring an amendment and notification.²

Notes

1. The Spring 2011 issue of Administrative Eyecare features a special supplement on healthcare reform-related changes to Medicare and what practices should do now to position themselves for success.

2. The materials presented here are intended to provide useful information about the subject matter covered. The author believes that the information is as authoritative and accurate as is reasonably possible and that the sources of information used in preparation of this information are reliable. But no assurance or warranty of completeness or accuracy is intended or given, and all warranties of any type are disclaimed. This information is not intended as legal advice, nor is the author engaged in rendering legal services. Nothing contained herein is intended as a replacement for the individual legal or professional advice you are urged to obtain. This information is presented only for illustrative purposes, and it should not be used to establish any fees or fee schedules, nor is it intended and it should not be construed as encouraging any user to take any actions that would violate any state or federal antitrust or tax statutes, or provisions of Medicare or Medicaid.

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