

Spotting the time bombs in your managed care contracts

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The primary focus of most managed care contract negotiations is rates. Many contracts are filled with boilerplate language, much of which can be overly long, complex, and inapplicable to a provider's needs. However, every term of a contract is binding, and many non-rate terms affect a contract's profitability. A term that is not clearly defined can act as a "time bomb" waiting to explode in the midst of the contract's performance. This article introduces some of the leading time bombs so that you may first recognize them and then defuse them or understand their effect on your contract's valuation.

A general approach to evaluating the language of a contract is to apply two rules. First, every term should have a purpose. If it has no purpose, it should not be in the contract. Second, the words used in the contract to describe a term should express the mutual understanding of the parties as to what the term means. Say only what you need to say, and make sure the written words you use fully say it. Applying these two rules is often more difficult than you would think. What follows is my top-10 list of the time bombs that can explode a managed care contract and how you can defuse them.

1) Discretion left to the payer

Even though it makes no sense to leave anything material to the discretion of only one party, it happens all the time. Often a payer aggressively seeks excessive discretion in its standard boilerplate on the assumption that the language will not be recognized or that through "compromise" much of it will be retained. Sometimes the parties agree to give the payer discretion when the issue is difficult to value and the parties are eager to bring the negotiation to a close.

A common example is the incorporation of new laws. Although both parties must comply with new laws that take effect during the term of the contract, there is often nothing in the new law that addresses which party bears the economic burden of compliance. It's left to the parties involved to decide who bears the economic responsibility. Yet often, providers agree to comply with new laws with no mention of a right to renegotiate rates in order to cover the law's financial impact. Providers often leave it to the

payer to determine whether an impact occurred and at what value.

It is in your best interest to leave nothing to the discretion of the payer: Either negotiate in advance precisely how to deal with the issue or, where the exact issue cannot be anticipated (such as the "law of the month" coming from your state legislature), specify that the parties agree to negotiate an amendment to the contract to address the financial impact of all changes imposed upon the provider's performance. Providers need to be vigilant, even in if their state has passed a "Provider Bill of Rights," as California has. Although the California law tried to fix the problem legislatively, it actually made it worse by allowing plans to include terms that permit material changes to the contract by the plan so long as they gave 45 days' notice to the provider. Under the law, providers have the right to terminate their contract prior to the implementation of the change. But it is very difficult for providers, especially smaller ones, to review, understand, and take action on changes in payer manuals in that short amount of time.

2) Attorney's fees clause

Typically, these clauses require the losing party to pay the attorney's fees of both parties. Generally, an attorney's fees clause is a good thing for providers because they do not sue payers unless they believe they have a strong case; it thus reduces the

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cost of pursuing a meritorious claim. Nevertheless, the risk of litigation is heightened when losing includes responsibility for the payer's attorney's fees. This risk is more easily borne by a large provider than a small one. **Discuss with your lawyer whether an attorney's fees provision suits the size of your organization.** Take into account your past relationship with the particular payer with whom you are contracting.

3) Termination provisions

Your termination provision should serve two purposes. First, it should let you end a relationship you want to end. Second, it should give you leverage in negotiating amendments to your current contract. You will find both goals difficult to achieve if, for example, your termination provision requires you to continue providing services to the payer's members for up to a year at the same rates as those in the terminated contract. You will have a cash flow problem if your contract allows the payer to withhold the last 3 months of capitation payments but doesn't require the company to pay your subcontractors for services furnished to the payer's members during this time.

The termination provision must be balanced. For example, there is a valid concern about continuity of care for patients in the midst of a course of treatment. But addressing that issue does not require the post-termination obligation to extend:

- beyond this course of treatment,
- to other patients,
- to an adverse selection impact by having all-acuity rates apply to only a few high-acuity patients, and
- to payment at old rates that no longer contribute to a reasonable rate of return to the provider.

In short, assume you will have to terminate the contract, and consider all of the potential issues in negotiating your termination provisions.

4) Overly broad audit provisions

Limits on a payer's right to audit are often ignored. But the timing of audit requests, and requirements for their completions, is crucial. The provider should not commit to a deadline for billing the payer when the payer can challenge the bill through an audit with no time limit on that challenge. **Provisions on "closing the books" on claims should apply equally to both parties.** A reasonable time period is often 1 year from the date of discharge or date of the initial bill. If providers don't limit the time in which an audit may be requested or completed, they expose themselves to an untenable situation: Payers can hire an audit company on a contingency basis that will then be motivated to audit claims going back for years. Disturbingly, there have been many instances in which payers have used audits as "payback": they demand hundreds of audits to retaliate against providers who have sought arbitration on unrelated issues.

The audit procedure should be addressed in the contract. Many providers have internal audit protocols that address issues such as the cost of copies and audit "fees." The protocols need to be included in the contract.

The scope of an audit should be clearly defined. Consistent with existing national health care billing guidelines, the purpose of an audit is not to reject the provider's rate structure or its prices. Rather, it is to remove items that were not provided and to add items that were provided but not billed.

5) Payment forfeiture for late claims

A payer has a legitimate interest in providers' claims being submitted promptly and accurately and in creating incentives to do so. But when a small number of claims fail to meet the contracted deadline, allowing

the payer to get this service for free is too harsh a remedy. **Negotiate a more reasonable incentive such as more time before an absolute non-payment cutoff occurs.** Some states have regulations that address this. **Another alternative is a sliding scale discount that applies to late bills.** Your state may have statutes and/or case law that reduce the probability that forfeiture for late claims will be strictly enforced. (See *Valley View Home of Beaumont, Inc. v. State Dept. of Health Services*, 146 Cal. App. 3d 161, 168 [1983].) Being aware of this and pointing it out should ease the negotiation of a reasonable prompt billing incentive.

6) No remedy for unexcused delay in payment

Although most contracts require payers to pay within certain time periods, these contracts do not contain a remedy in the event that a payer fails to meet the obligation to pay promptly. Many states now have a "prompt payment" statute or regulation that requires the payer to automatically pay interest on claims that are not paid within prescribed time limits. These remedies should not be neglected, though in practice they do not necessarily solve the problem. Of course, a provider can always terminate his or her contract for material breach when the payer does not pay. However, most providers would rather be paid than wiggle out of a contract.

In negotiating your contracts, consider discussing remedies for delay in payment and billing together. This will balance the negotiation by not allowing one party to take an aggressive position on the issue when it does not have to perform, without also having to abide by that same position when it does have to perform. The result may be greater balance between what the contract requires when it comes to both prompt billing and prompt payment.

7) Evergreen clause

This type of clause automatically renews a contract for another term (typically 1 year) if the contract is not terminated. It could play a useful role in routine contracts that are unlikely to require much change over time. However, they can create more danger than benefit.

In a market where costs are increasing and providers will need to raise contract rates, an evergreen clause only favors the payer. We have seen too many instances in which the provider forgets to terminate the contract or no formal notice of termination is given because the parties are in the midst of renegotiation. In such cases, the payer claims that as a result of the absence of a timely formal notice of termination, the contract is automatically renewed. Even if providers have a legal remedy to extract themselves from this situation, they will have lost much leverage in the renegotiation.

It's best to avoid evergreen clauses. If a payer insists on one, try to make the deadline for giving notice of termination close to the end of the term. You are less likely to miss a deadline 30 days before the end of the term than one that is 6 months before the end of the term. **This is my favorite strategy with a payer that insists on an evergreen provision:** The week after the new term takes effect, I serve the payer with a written notice of termination, effective at the end of the newly agreed-upon term.

8) Missing or poor definitions

A huge source of contract disputes is the missing or poor definition. For example, a contract may have an "X percent of premium" capitation rate, but no definition of "premium" or of the methodology used to calculate the X percent. Another example: The contract has a rate for emergency services, but de-

finer "emergency" so narrowly that it does not encompass services that fall within the definitions of an emergency medical condition formulated by the federal Emergency Medical Treatment and Labor Act and by state laws. Is "Group shall be entitled to receive direct payment as determined by Payer for covered services" a sloppy way of saying the payer determines what services are covered? Or did the parties really mean to agree that the payer determined the rate of payment for covered services? Sometimes the solution is not easy. The parties may not have anticipated a particular situation that arises. More frequently, the payer is trying to stretch the meaning of a term beyond a reasonable interpretation or beyond what the parties could reasonably have contemplated at the time the contract was negotiated. Their claim: We had an agreement.

Be aware of the importance of definitions. **See that the contract states the mutual expressed intention of the parties at the time of contracting.**

9) Setoff provisions

The payer will always want the right to set off overpayments from future payments owed to the provider. On its face there is nothing unreasonable about such a term. However, it is susceptible to abuse. For example, instead of a mistaken payment of the same bill twice, the payer may decide to unilaterally change how it *interprets* a contract rate and set off the difference between what was paid over the past year at the original interpretation and what *should* have been paid at the new and improved *interpretation*. The absence of a time limit for audits often contributes to this result. The payer accepts and pays for charge X for 3 years. The contingency-paid audit company then goes back to audit high dollar claims over these 3 years and rejects all charges for X as *unbundling*. Now the payer takes back hundreds of thousands of

dollars of old *underpayments*.

What is at issue here is who should control the disputed cash a payer has paid, but now wants back, because the payer wishes to retroactively change its approach to the contract. When such a practice is cast in this light, some payers are reluctant to admit that they want the right to do this. An effective approach to protecting the provider from this abuse of setoff rights is to **negotiate a time limit in which a setoff can occur, just as there are time limits in which to submit bills, pay bills, and conduct audits.** It can be negotiated in the mutual interest of both parties to close the books and protect themselves from large retroactive changes to financial performance of the contract.

10) Incorporation of payer's manuals

The biggest time bomb by far is an overbroad incorporation of provisions set forth in payers' administrative manuals. Payers have a legitimate purpose in incorporating their administrative manuals; realistically, they cannot be expected to set up 300 different administrative procedures to deal with the specific administrative requests of 300 providers. The abuse occurs when the payer argues that it can unilaterally change a material term of its contracts, such as the contract rates, simply by making a change to its in-house manual.

Here are some basic steps you can take to protect yourself:

If a provider agrees to an incorporation of manuals, the contract should clearly state that the manuals are subordinated to the terms of the contract.

Spell out the fact that the purpose of the incorporation provision is administrative only, and the payment rates and all other material terms of the contract are governed solely by the contract.

Specifically identify which manuals are being incorporated. Agreeing

to an incorporation of *all policies* will allow the payer to argue that any ad hoc letter the payer writes constitutes a *policy*.

Require the payer to give the provider copies of what is being incorporated. It is a daunting task to review hundreds of pages of manuals, but this requirement limits what the payer can later claim was incorporated.

Specify the way in which amend-

ments to the incorporated manuals will be forwarded and reviewed and how the parties will deal with any resulting increase in the cost of contract performance.

Of course, every contract has the potential for many unique time bombs. These top 10 illustrate why all the words in a contract are important and how they can be used in unanticipated ways. Knowing this infor-

mation, and insisting on specific definitions of terms, should help enable you to formulate contracts that come closer to delivering the bargain you thought you had.

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Commentary

Community experience

A practice-based COO gives his views on the minefield that is managed care contracting

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IN MY 21 YEARS in the healthcare management industry, I've observed that most physicians and physician practices tend to negotiate contracts with a focus on rates and not on the language and terms that often favor the payer economically. Most payers employ experienced business, financial, and legal/regulatory professionals to develop and negotiate their managed care contracts. These experts minimize payers' business and legal exposures and maximize their strategies and opportunities. I encourage physicians and physician groups to employ the same types of experts to level the playing field as much as possible. Often, the actual reimbursed rates are not the negotiated rate, unless the contract language and terms strongly support and enforce all the parties' intents.

I disagree with the author on his point about attorney's fees. I believe most providers would prefer that their contracts allow them to recover legal costs. Based on my

own experience on both the payer and provider sides, most providers resort to legal actions after exhausting all other remedies outlined in the agreement to avoid ending a relationship that may cost them patient volume—a major economic impact. On the other hand, most payers today seek binding arbitration as a way to resolve their disputes and prefer that parties share legal fees equally to discourage providers from seeking legal action. The primary reason for this shift in legal strategy by payers was that in most cases providers have been the plaintiffs and often the winners in those cases.

I agree with the author that termination clauses need to be balanced, both for cause and without cause. However, a provider needs to consider the importance of each contract in evaluating what termination clauses, especially without-cause clauses, should be incorporated in the contract. For example, if a contract represents in excess of 10% of the provider's patient volume

and revenues, the provider needs to fully understand that by asking for a shorter without-cause clause period to terminate the agreement, the payer will have the same option. In most cases this would elevate the payer's leverage, especially in larger markets where there are many other physicians/providers who have unused capacity.

As for the continuity of care provisions, I think Mr. Fedor's points are more applicable to hospital providers than to physicians. To avoid putting patients in the middle of a dispute, providers need to consider the state-mandated laws that obligate payers and providers to address post termination clauses as part of their negotiation. California requires both parties to address their post-termination relationship so that patients have access to their terminated providers for up to 12 months.

Regarding audits: It's important to note that physician providers have the same ability as hospitals

to recover underpayments. Unfortunately, unlike hospital providers, physicians seldom exercise such rights, mainly because of limited resources and fewer recovery firms that serve physicians as clients.

I can't say I agree with the author's favorite strategy of giving an early termination notice. To me, that suggests a lack of commitment to the relationship; it could encourage the payer to seek other providers. It's true that "evergreen language"

is to the payer's advantage—that is, unless the provider seeks rate adjustments that would become effective as the contract automatically renews. Through such an arrangement, the provider can shift the policing of the automatic renewal to the payer.

Regarding setoffs: I think providers should avoid agreeing to this arrangement. Each claim should be addressed separately through payments and refunds. Otherwise, payers could mount challenges down the road as provid-

ers evaluate contracts and/or prepare for future negotiations. However, if a payer insists on the right to offset an overpayment against future payments, I would suggest that the provider insists on being notified of the overpayment before payers can set off payments and that the payer identify the case and allow the provider to refund the *undisputed* overpayment within the same time frame the payer would have to settle its claims—generally 45 business days.