Managed Care Contracting for Physicians

Aynah Askanas, JD
San Francisco, California

Family physicians are, with increasing frequency, entering into contracts with health maintenance organizations (HMOs), preferred provider organizations (PPOs), independent practice associations (IPAs), and other types of managed care organizations (MCOs). It is important that physicians understand the ramifications of these contracts. While it is best that physicians seek the advice of an attorney before signing such contracts, many physicians do so without obtaining expert advice. The purpose of this article is to assist physicians in understanding and negotiating managed care contracts. Depending on the "market" in your area, ie, how many physicians or groups are competing for the same contract, you may be in a position to negotiate to delete undesirable contract language and to add language that benefits you. Most contracts are not "set in stone."

Sample language in this article is taken from an actual managed care contract, but the name of the plan has been replaced with the word "Plan." This article is written without detailed information on the particular circumstances of the contracting physicians, their relative bargaining power, or the policies of the contracting MCO; therefore, it suggests a wide variety of possible issues related to contract negotiation. We cannot predict a physician's chances for success in negotiating any of the points raised in this article. This article does not constitute legal advice. Physicians needing personal legal advice should consult an attorney experienced in physician business matters.

LIST OF CAPITATED SERVICES BY CPT CODE

Your capitation contract should state not only the per member/per month (pm/pm) rate but also a list of services covered by the capitation payment by CPT code. You must know the services that the pm/pm amount will cover before you begin determining your probable utilization of those services and whether the proposed payment is high enough.

Obtaining a list of services by CPT code also enables you to see whether there are services listed that you are not qualified to perform. Capitated services could include procedures that you are not equipped to do, for example, dermatologic surgery; in-office Holter monitoring and treadmill stress tests; extremity radiographs; and treatment of undisplaced fractures. While few primary care capitation agreements now include services such as these, some specialty procedures are becoming more common. If you or your group are unable to perform some of the listed services, you will likely be required to pay the cost of referring patients for them. This expense should be considered when determining whether the capitation payment is adequate.

MALPRACTICE LIABILITY HEIGHTENED

Do not be tempted to perform procedures for which you are not qualified because they are paid under your capitation. Malpractice liability risk increases in several ways when physicians attempt to treat a condition beyond their competence. Necessary tests or treatment may not be performed. If something goes wrong, delay in referring the patient to a specialist, which often delays treatment, could also result in a malpractice suit. Depending on the circumstances, the standard of care applicable to specialists may be applied, even though the care was provided by a primary care physician. A plaintiff's attorney will focus on anything that can compromise objectivity, including financial incentive not to refer. A family physician should refer to a specialist whenever (1) the care requires technology that the physician does not have, and (2) the physician has never done the procedure before or has not done it for a long time.

In the California case of the *Department of Corporations v TakeCare* (Department of Corporations file No. 4.33-0290), the TakeCare

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From the California Medical Association Legal Counsel, San Francisco. Requests for reprints should be addressed to Aynah Askanas, JD, California Medical Association Legal Counsel, 221 Main St, San Francisco, CA 94105.

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HMO authorized a urologist who specialized in the care of adults to perform the removal of a Wilms' tumor in a child, even though he had never removed such a tumor. Although the surgery was ultimately performed by a pediatric surgeon experienced in removing Wilms' tumors, TakeCare was fined $500,000 in part for authorizing the urologist who was purportedly not experienced in caring for children to do the surgery. (TakeCare is currently appealing the fine.) Although the family refused to allow the first urologist to perform the surgery, if he had and if there had been a bad outcome, any financial incentive arrangement would likely have been used by a plaintiff's lawyer as evidence against that physician.

In another example, a Ventura County Superior Court jury ruled that the husband and son of a Simi Valley woman should receive $3 million in damages from two doctors who allegedly failed to diagnose her colon cancer promptly. In *Ching v Gaines*, CV-137656, Joyce Ching presented at the physician's office in 1992 with abdominal pain. Her family alleged that the doctors missed "red flags" pointing to cancer and denied her requests to see a specialist. When she was referred, her condition was diagnosed as cancer that was too advanced to be cured. Ching, age 35, died in April 1994. In their complaint, her husband and son alleged medical malpractice and wrongful death causes of action. They also argued that the HMO's contract encouraged the physicians to save costs, thereby breaching their duty to the patient.

These types of malpractice lawsuits, which focus on financial incentives, are becoming common. If you do not feel entirely competent to perform certain services, you should refer to another physician competent to treat the particular condition, regardless of financial incentives.

LIMITING YOUR RISK UNDER CAPITATION

Family physicians need to negotiate a contract that addresses the danger of underutilization with capitation. The following is a provision designed to reduce the risk of capitation payments that are so low that they create an undue incentive toward underutilization. Optional provisions or those that will vary according to the contractual arrangement are enclosed in brackets:

> The capitation rate may fail to meet the intended financial objective of providing physician compensation at least equal to [___% of RBRVS for the physician locality fee schedule] or [____% of what the Physician would have received on a fee-for-service basis]. After a yearly reconciliation, if projected necessary utilization is exceeded, the physician will be paid additional amounts to ensure that the [ ]% threshold has been reached.

For example, if the physician's total fee-for-service collection would have been $555,864, a 20% discount would mean subtracting $111,173, to equal $444,691. Assume the actual capitation payments were $327,544. This would be subtracted from the contractual floor and the plan would owe the physicians $117,147. This type of mechanism prevents physicians from "losing their shirt" on capitation contracts. Such clauses require physicians to keep track of how much they would be receiving on a fee-for-service basis. This is accomplished by using encounter data or Health Care Financing Administration (HCFA) 1500 forms, which are usually required to be submitted with capitation contracts anyway.

"CARVE-OUTS"

Carve-outs are a listing of services not covered by the capitation payment but paid outside the capitation on a fee-for-service basis. In contract negotiations, family physicians should try to "carve-out" services that are expensive, time-consuming, or whose utilization is unpredictable. Carve-outs are rarely offered by the MCO; the physician generally must bring this up in the negotiation process. The following is an example of carved-out services:

> IPA agrees to pay PCP for the following non-capitated services on a fee-for-service basis in accordance with the maximum allowable rates stated in Attachment C-1.
>
> 1. Initial newborn visits
> 2. All office surgeries
> 3. Assistant surgery fees
> 4. Hospital visit—initial history and physical
> 5. Pediatric and adult vaccines

REQUIREMENT TO CONTINUE PROVIDING SERVICES UPON TERMINATION

Most managed care contracts require that upon termination, physicians continue providing services for active patients for a specified time. This period may be stipulated by state law. The problem with this requirement is that contracts also state that after termination, the physician agrees to accept the contracted (capitation) rate. Capitated physicians should not agree to continue accepting capitation after the contract is terminated. The contract should state that if the physician is required to provide services after termination, it will be at a fee-for-service rate only, as capitation is reasonable only if the physician is being paid for patients who are not in active treatment. Moreover, patients who continue to see you after your termination are likely to be sicker patients who require extensive services, thereby furthering your financial losses.

COORDINATION OF BENEFITS

"Coordination of benefits" principles allow a secondary payer to reduce payment when a primary payer has already paid for a particular service. Such clauses do not work in capitation contracts and should be deleted. Payment from a primary payer is normally reduced by the secondary payer's payment so that the physician receives no more than the secondary payer's contracted rate or the physician's usual and customary rate for a particular service. There is no way to coordinate benefits in this way when one of the payers pays capitation. The capitation payments cannot be subtracted from another plan's payment. Contracts should specify that payments received from secondary payers are kept outright by the capitated physician.

HOLD HARMLESS CLAUSES

The following is an example of a "hold harmless clause":

> The Physician shall be responsible for the quality of care rendered to the participants and shall hold harmless, indemnify, and defend the HMO, its administrators, officers, directors, and trustees from any litigation costs, claims, judgments, liability and damages resulting from the medical care rendered to the participant under this contract, including any legal damages, costs of investigations, attorney's fees or any other costs.

The execution of a hold harmless clause may result in the physician assuming liability for the MCO. Most professional liability policies specifically exclude contractually assumed liability from coverage. The above provision causes the physician to "contractually assume" the liability of the MCO. Consequently, the physician may be going bare as to such assumed liability. Physicians should negotiate to delete these types of provisions and would be prudent to consult their professional liability carrier.

Physicians should be wary of any provisions that attempt to insulate the other party from sharing the risk of incorrect utilization review or other decisions, or attempt to shift that risk to the physician. The MCO should bear the risk of its own negligent or improper coverage and utilization review decisions. Further, it is advisable that physicians make sure that the MCO with whom they are negotiating is insured for or sufficiently solvent with respect to this legal risk. Otherwise, the physician may end up being the sole "deep pocket."

CONTRACT AMENDMENTS

Amendment provisions address how physicians and the MCO are to make changes in the contract after it is initially signed. There is one common problem with amendment provisions in managed care contracts. Generally speaking, physicians are required to get the MCO's written agreement to any amendment; however, the MCO uses various contractual language that allows it to change the contract without physician consent. It is essential that physicians carefully read the contract, crossing out any provision that allows the MCO to unilaterally amend the contract and include a provision that permits amendment *only* upon the written agreement of both parties, as follows:

> The contract may be changed or amended only by the mutual written consent of both parties hereto.

With this type of provision, future changes to the contract must be agreed to in writing by both parties. Even with this type of provision, other provisions within the contract that expressly authorize changes to be imposed unilaterally by the MCO may be binding, unless they are deleted from the contract. An example of this type of provision is

one that allows the fee schedule to be changed at the MCO's discretion.

"GAG RULES"

"Gag rules" in physician managed care arrangements are becoming infamous owing to bad national press. Gag clauses prohibit physicians from speaking to their patients about certain matters. Here are three examples of contractual gag rules:

> If the primary care physician and group cannot agree on a proposed plan of treatment, the disagreement regarding said plan or treatment shall be submitted to the Plan Board of Directors. *At no point should any disagreement regarding the treatment plan be discussed with an Enrollee.*

> In no event shall Specialist Physician market or offer to enrollees services beyond those which are prescribed by the referring primary care physician.

> This contract may be immediately terminated for provider's direct contact of [plan] members in regards to matters pertaining to the [plan] without [plan's] prior written approval or providers making any repeated disparaging remarks about [plan] or expressing opinions regarding [plan] or any of its affiliates that are negative in nature.

Gag rules constitute an undue interference with the physician-patient relationship. Physicians should negotiate to delete these provisions, as they could require physicians to withhold information necessary for treating patients and providing quality patient care. Many states are currently passing laws that prohibit such clauses.

APPEAL OF TERMINATION (Right to a Fair Hearing)

Some contract provisions, such as the following, may prohibit physicians from appealing when an MCO terminates their contract:

> Physician group agrees that any [plan] decision to terminate this Agreement shall be final. Group further agrees that its physicians shall have no rights to appeal the decision of the [plan] through any formal or informal administrative hearing or review process nor shall they have any other due process right to appeal a [plan] decision to terminate this Agreement.

Such provisions are unfair. Why should not the physician have the right to appeal a termination? What if the termination is based on inaccurate information? For example, what if the wrong "Dr John Smith" was terminated? Or, what if the termination was based on an erroneous UR profile? Recent court decisions* have concluded that MCOs are required to accord physicians a fair procedure whenever the physician's contract termination affects important economic interests. Physicians should negotiate to delete such provisions. Note that if the contract is terminated for quality-of-care reasons, the physician is likely to be entitled to a hearing under state or federal law, or both.

REQUIREMENTS FOR PATIENT APPOINTMENT AND WAITING TIMES

Managed care contracts are now beginning to dictate to family physicians precisely how long they may keep a patient waiting in the office to be seen for an appointment. Contracts are also telling physicians how long a patient should wait between calling for and receiving an appointment. Examples of these provisions include:

> For stat referrals, a provider agrees to see enrollee within twenty-four (24) hours of notification. For routine referrals, a provider agrees to see enrollee within two (2) weeks from the time the enrollee calls for an appointment.

**See Delta Dental Plan of California v Charles Banasky, 27 Cal App 4th 1598 (1994); John Ambrosino, DPM v Metropolitan Life Insurance Company, 899 FSupp 438 (ND Cal 1995).*

> Participating provider agrees to record the time that the [HMO] participant arrives at his or her office and the time that the participant is seen by the physician, and record such times in the medical record.

> Physician shall maintain practice policies which support the provision of Medical Services to Members according to the following standards set forth below. Physician agrees not to exceed the specified intervals between a Member's request for service and the date/time Medical Services are rendered:
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> | | |
> |---|---|
> | (1) Physician exam/ well-baby examination | 30 calendar days |
> | (2) Nonurgent examination | 7 calendar days |
> | (3) Consult/specialist referral | 14 calendar days |
> | (4) Urgent examination | 24 hours |
> | (5) Emergency examination | Immediate access |

These types of requirements are inappropriate and, whenever possible, physicians should negotiate to delete them from the managed care contract. A physician's schedule clearly cannot be arranged according to preset guidelines. The physician's schedule is affected by many unpredictable factors, such as the number of emergencies, examinations that take longer than expected, and physicians' unanticipated days off. Expecting physicians to agree to such a schedule is unfair and inappropriate. Moreover, there is the danger that such requirements will be used by a plaintiff's malpractice lawyer to argue that the physician's failure to provide care within the required intervals was the cause of the patient's harm.

When this type of provision cannot be deleted from a physician's managed care contract, the contract should be amended to specify that these are merely guidelines, and that it is understood that, because of many outside factors, physicians cannot be expected to adhere strictly to the stated guidelines. Finally, before agreeing to any such requirements, be sure they are reasonable. For example, can patients really expect a nonurgent examination from a physician within 7 days?

DOWNCODING

The following types of clauses that permit "downcoding" are beginning to appear in managed care contracts:

> IPA reserves the right to change codes based on procedures.

The MCO should not change the physician's billing codes unless the procedure was not medically necessary or there was no supporting documentation. If this sentence cannot be deleted from the contract, it should at least state that before a code is changed, the MCO will give the reason for the change to the physician in writing.

CONTRACT INTERPRETED AGAINST CONTRACT DRAFTER

The following type of provision requires physicians to waive the law of many states that contracts will be construed or interpreted against the party who drafted the contract (usually the MCO).

> Neither HMO nor the Provider shall be deemed the drafter of this agreement. If this agreement is ever interpreted or construed by a court of law, such court shall not construe this agreement or any provision hereof against either party as drafter.

In physician participation agreements, this state law works to the physician's benefit. Therefore, the physician should not waive this law. It is only fair that the party that drafted the contract be responsible for any of its ambiguities, inconsistencies, or errors. This language should be deleted from the contract.

CONCLUSIONS

Health care contract law is in a state of formation, partly because of market forces that are also shaping medicine. Physicians must be aware of the effect contracts have on day-to-day administrative responsibilities. Additionally, physicians must now learn to closely read their contracts and develop a

good working relationship with a lawyer who understands local health care law. This is now a part of what is required to take good care of your patients.

Appendix: Publications for Further Information

The following is a list of some of the California Medical Association (CMA) publications that assist physicians with managed care contracting. Your state medical association may offer similar publications. If not, CMA's publications should be helpful to family physicians in all states. To order, call 1-800-882-1CMA.

Physician's Managed Care Manual, Second Edition

This manual explains what physicians should know about a plan before signing a managed care contract. The manual discusses capitation, financial incentives, contract negotiations and amendments, point-of-service plans, risk-sharing arrangements, contract terminations, etc. Price: CMA members—$50; nonmembers—$100.

Model Managed Care Contract

What language should go into your managed care contract? Is the plan's contract problematic? Finally, there is help. CMA attorneys who review thousands of managed care contracts have just completed CMA's *Model Managed Care Contract* for physicians and medical groups. Capitation provisions, termination provisions, fee for service provisions, risk withhold provisions, hold harmless clauses—everything is covered . . . but, of course, we left out the bad language! Compare a contract sent to you against the language drafted by CMA attorneys. How does your contract measure up? Are there terms you would like to see included? Removed? Understand your options before you negotiate. Price: CMA members—$25; nonmembers—$50.

What Physicians Need to Know About Integrated Delivery Systems

This text discusses physician arrangements with management services organizations (MSOs), physician-hospital organizations (PHOs), foundations, and other systems. This guide answers questions such as:

- How can you ensure physician control and autonomy?
- What contractual provisions should you include?
- What legal issues should you address to avoid trouble?
- What should you discuss with the other party before signing?

A model MSO contract is included. Price: CMA members—$50; nonmembers—$100.