

Payer Contracts Require Close Scrutiny

BY BRIAN L. ANDREW, JD

As competition among third-party payers becomes increasingly acute, providers face a variety of managed care arrangements. Reviewing and negotiating payer contracts can be a difficult and time-consuming task. However, providers must closely scrutinize such contracts because the liability consequences of certain provisions can be great. For example, contracts may include provisions that:

- Affect the way services are arranged or provided (e.g., prohibit subcontracting services)
- Impose obligations that are perhaps not covered by insurance (e.g., require compliance with a payer's policies and procedures without giving the provider the opportunity to review them properly)
- Impose unacceptable precertification conditions for the provision of services
- Generally limit the provider's ability to exercise proper and independent judgment regarding patient care

Providers' liability exposure under managed care contracts should not be underestimated. To limit payers' efforts to "manage" providers' utilization, providers should not follow a predetermined formula when negotiating a contract with a payer.

Providers should thus develop a negotiation strategy tailored to each individual payer plan. They might have to accept certain problem clauses (e.g., easily amended utilization review policies or open-ended time frames for claims processing) for the payer to agree to the contract. Correspondingly, healthcare providers at times should insist on the inclusion (or exclusion) of certain important provisions as *their* condition to signing (e.g., include termination at will, or exclude indemnification by the provider).

Certain key contract issues should be considered to minimize liability risks associated with payer arrangements and to ensure that the provider can live with the contract that it ultimately signs.



*Mr. Andrew is
an attorney with
Greensfelder,
Hemker & Gale,
St. Louis.*

UTILIZATION REVIEW/QUALITY ASSESSMENT

The contract should specify utilization review/quality assessment (UR/QA) procedures that are easy to follow and afford an adequate appeals process. If patients must perform tasks such as selecting a gatekeeper physician, getting referrals for certain services, and obtaining preauthorizations, those features should be described in detail. The appeals procedures should ensure prompt and personal response if the provider disagrees with a UR/QA determination.

If a UR/QA disagreement remains unresolved, the provider should document objections. Ultimately, to avoid liability exposure, the provider may have to treat the patient's medical condition regardless of the payer's UR/QA determination, which could result in nonpayment for the service.

MOST FAVORED NATION

Often a payer will attempt to include a "most favored nation" clause, under which the provider agrees to incorporate automatically certain payment provisions favorable to the payer in any contracts that the payer or provider subsequently negotiates with *other* entities in the area. The provider is thus agreeing in advance to include certain provisions set forth in the service contract. Because the provider is essentially negotiating away control of the contract's terms, the parties involved should consider deleting such provisions from any contract.

TERM AND TERMINATION OF CONTRACT

Since courts have previously held that payers could be liable for negligence if their acts are arbitrary or unreasonable, providers should be able to terminate a payer arrangement that interferes with appropriate medical decisions. Therefore the contract should include a termination provision that does not impose unreasonable advance notice requirements (e.g., six months) or penalties.

Also, the contract should address a termina-

tion's effects on patients (e.g., hospitalization on the date coverage ceases). Because disputes often arise regarding termination issues, many states now have laws affecting renewal or nonrenewal of contracts.

REDUCTION IN PAYMENT

Some payers require providers to accept a pro rata reduction in their payments in the event that a payer is unable to pay under the terms of the contract. This could easily result in a greater shift of risk to providers, with adverse financial implications. Therefore providers should resist any attempt to include such language. If that is not possible, providers should ensure that the termination provision permits a quick exit from the relationship.

INDEMNIFICATION

Many contracts require the provider to indemnify the payer for certain losses relating to the provider's acts or omissions. It is generally in the provider's best interest to avoid indemnification requirements, or at least to demand a cross-indemnification provision, whereby the payer agrees to indemnify the provider for the payer's acts or omissions. Also, before signing any contract, the provider must confirm that liability for its obligations pursuant to the contract are covered by its insurance and that coverage will not be jeopardized by entering into the contract.

ACCESS TO MEDICAL RECORDS

Payer contracts usually require the provider to maintain standard medical records. The contract's provisions should be acceptable to the healthcare provider as long as they do not exceed those of state regulations and licensing and accreditation bodies.

A patient whose medical information has been improperly exposed might be able to sue based on defamation, invasion of privacy, breach of contract, or some other regulatory remedy. A contract should thus permit access to medical records only to the extent permitted by law and the provider's rules and regulations. The cost of reproducing such records should be borne by the payer.

INSURANCE

The contract should require the payer to maintain a minimum level of professional liability insurance

and to notify the provider of any modification or loss of such coverage. The provider should determine what insurance protection the payer maintains to cover any payer UR/QA activities. The provider should also expect the contract to require it to verify *its* insurance coverage for the payer.

ADVANCE NOTICE OF CHANGES

Providers should not agree to provisions that give the payer unilateral power to implement or otherwise change policies and procedures without first giving the provider time (at least 30 days) to review and approve such changes. Such changes could seriously affect key provisions, such as UR\QA procedures, insurance rates, and termination rights, that the provider may have negotiated into the contract. The provider should be able to terminate the contract if changes to the policies or procedures are unacceptable.

EXCLUSIVITY

Although not frequently negotiated, a provision appears in some contracts that prevents or limits the provider from participating in certain other payer or managed care arrangements. Such provisions restrict available options, may have antitrust implications, and should generally be avoided.

VERIFICATION OF ELIGIBILITY

A provider should be able to rely conclusively on the process established for identifying payer's members. The provider should determine whether the duties of each party—in connection with verification of eligibility—are clearly defined in the contract. For example, the provider might insist that there be a 24-hour, toll-free telephone number and membership identification cards; that the payer respond to calls for verification within 24 hours or authorization will be deemed granted for any procedure or admission; and, perhaps most important, that if the payer verifies eligibility, it will remain liable for payment even if it made an error.

BALANCE BILLING

Finally, most states prohibit health maintenance organizations (and, in some states, preferred provider organizations) from balance billing members for services that the managed care entity has contracted to arrange or provide. Although these prohibitions are statutory, it is always best to have them specifically included in the contract. □

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