Provider Networks

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Area of Rapid Change

- Experience of commercial payers in the health insurance exchange market
- Medicare experiments with ACOs and other value-based payments
- New emphasis on narrow networks, risk/gainsharing, and utilization management
- Re-emergence of provider-owned plans

Rapid Change Continued

- Big data – data mining, EHRs
- Add up to better tools to manage care with current information
- Looking for better value – emphasis on outcomes and quantifiable quality metrics
- Estimate of 15% of annual healthcare spending will be in some form of pay for performance model

MANAGED CARE CONTRACTING

Contracting – Parties

- Parties to managed care contracts, both payers and providers, frequently want the contract to include "affiliates"
- This needs to be defined with particularity so both sides know who may benefit from the contract
- Rights to enforce contract should be limited to signing parties
- Signatories responsible for breaches of affiliates and any indemnity obligations

Contracting – Parties

- Any willing provider statutes such as those in Idaho and Utah limit the ability of a payer to restrict networks
- Practically speaking, network can be restricted to one set of providers if terms of participation require clinical and financial integration and risk/gain share

Contracting - Risk Share

- Define “budget” or baseline for costs of care
- Define “costs” and how calculated
- Address amendments to the fee schedule or other mechanisms used to calculate costs
- Reconciliation and timing of risk share payments
- State insurance limitations on assumption of financial risk by unauthorized insurers

Contracting – Quality Metrics

- Define the quality metrics with certainty
- Address right to amend the metrics
- Establish the quality goals to yield shared savings
- Address collaboration: EHR and data sharing

Contracting – Quality Metrics

- Address changes to the population during any measurement period (which patients count to measure provider performance)
- Address changes to provider group (which provider's performance is measured)
- Formulas for calculating target achievements should have a buffer to account for random variation (ex. ±1%)

Contracting - Indemnity

- Indemnity provisions are difficult to avoid
- Providers must be careful to ensure that liability insurance will cover indemnity obligations
- Idaho law requires mutual indemnity of equal scope ("What's good for the goose…")

Contracting – Amendments

- Unilateral amendment provisions are common – the payer can amend by providing X days' notice. Providers may accept amendments or terminate participation after a certain waiting period (i.e. 60 days)
- Often a notice and comment or other dispute resolution provision is included to avoid having to terminate the agreement

Contracting – Amendments

- Plan policies and other "extrinsic" documents should be included in the amendment provisions
- Unilateral amendments can be limited to amendments required by law (and this phrase defined with precision) or for the payer's accreditation
- State law may limit the enforceability of a unilateral amendment provision

Contracting – Termination

- Termination bases for a single provider are different than termination bases for the entire network
- Example: failure to be licensed affects a single provider; failure of the payer to deliver sufficient covered lives affects the entire network
- Contract should address bases for terminating a single provider separately from bases for terminating entire network

Contracting – Termination

- Notice: Ensure that the contract requirement for notice is sufficient to provide actual notice. Risks of undelivered email or faxes may favor return-receipt mail or signature required delivery

Contracting – Termination

- Contract will usually continue for some period following termination for patients receiving treatment at the time of termination
- Contract should specify how long this period is and when contracted rates expire
- Contract should address transitioning patients

Contracting - Termination

- For capitation, risk-share, or value based arrangements, termination will affect claims run-out, reconciliation, timing of payments, calculation of targets
- For fee-for-services, termination will usually create a drop-dead date for submission of claims
- Contract should address all of these scenarios

FORMATION OF PROVIDER NETWORKS

Antitrust

- Federal law (Sherman Act, Clayton Act, FTC Act, Robinson-Patman Act)
- State law – most states have an anti-trust law. Example is Idaho Code Title 48, Chapter 1

Antitrust

- 1996 joint issuance of the Department of Justice and the Federal Trade Commission "Statements of Antitrust Enforcement Policy in Health Care."
- Networks avoid *per se* anti-trust violation by financial or clinical integration
- With financial or clinical integration, the "rule of reason applies" – balance of anti-competitive effects vs. pro-competitive effects

Antitrust – Clinical Integration

- Defined in the "Statements of Antitrust Enforcement" and numerous FTC cases and guidance
- Some key characteristics:
  - Clinical protocols and benchmarks
  - Data monitoring and reporting
  - Contractual model and accountability
  - Technology infrastructure
  - Lack of market power

HIPAA, Stark, AKS, CMP

- Provider networks must also address the "standard" guard rails in health care transactions
- HIPAA
- Stark law (physician referrals)
- Anti-Kickback Statute
- Civil Monetary Penalties law
- Standard network models generally can fit within established "safe harbors" and exceptions

OUT OF NETWORK ISSUES

Out of Network Groups Plans

- Emerging issue
- TPAs and other "consultants" are advising self-funded employer group health plans to cancel network contracts

Out of Network Group Plans

- Common scenario is as follows:
- Health plan card bears the name of a TPA with a contracting network
- Health plan uses the TPA to process claims but does not enter into a network agreement
- Provider accepts card and takes assignment of benefits under the plan

Out of Network Group Plans

- Provider submits claims to plan for pre-authorized covered services based on historical reimbursement rate
- Plan document is amended to limit amount of provider reimbursement for services (i.e., 125% of Medicare)
- Provider attempts to balance bill the patient for difference between charge for services and plan reimbursement amount
- Plan defends that provider as assignee of benefits must dispute the charges under the plan's claim procedures

Out of Network Group Plans

- Under claims procedures, the plan reviews the services provided and determines that the amount paid is appropriate
- Provider sues and loses
- *See Floyd Medical Center v. Warehouse Home Furnishings Distributors,* 4:11-CV-15 (M.D. Ga. Apr. 25, 2012)

Out of Network Group Plans

- How to address?
- Do not accept assignment of benefits from patients who are out of network
- Bill the patient directly. The patient may then seek reimbursement from the group health plan
- Or require plan to agree in advance to a payment

Out of Network Group Plans

- Providers who have been “stung” by this practice may have legal remedies
- Ex. state or federal conspiracy and fraud laws, breach of duties under ERISA