8 provisions that can make or break pay-for-performance contracts

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Pay-for-performance agreements can either weigh physicians down with a new load of administrative burdens or provide opportunities to be rewarded for the high-quality affordable care they already deliver.

The direction these agreements take often depends on the details of a contract’s provisions related to patient assignment, claim submissions, access to data, quality measures, performance determination, payment and dispute resolutions.

An AMA resource, “Evaluating pay-for-performance contracts,” provides insights on key questions to ask regarding these issues and offers model contract language that can help physicians avoid pitfalls.

Government and private payers are increasingly turning to alternative payment models that seek to shift all, or a portion, of the risk of providing health care from the payer to physicians and others who provide health care services. Pay-for-performance is often the first step many payers and physicians take on their risk-based contracting journey.

Nearly 40 percent of physicians said in a 2016 AMA survey that they received some payment from participating in pay-for-performance programs.

In comparison, 34.8 percent participated in bundled payment, 25.1 percent in capitation and 16.7 percent in shared savings.

Meanwhile, a majority of practices operating as a medical home or participating in an accountable care organization (ACO) were involved in pay-for-performance agreements, the AMA survey found.
“Evaluating pay-for-performance contracts” provides guidance on choosing which payment model may be appropriate for your practice. It also suggests getting advice from peers on understanding the underlying goals these models are designed to achieve.

There are eight common pay-for-performance contract provisions that should be identified and scrutinized, the AMA advises.

**Patient assignment.** Provisions on patient assignment consume a significant amount of time and attention during negotiations as the level of risk each party assumes depends on where lines are drawn on this subject. Physicians should push back if a plan attempts to assign patients retrospectively.

“The agreement should provide for most patients to be assigned prospectively, with the ability to reconcile the list at the end of the performance period to account for patients that have left or entered into the physician’s care during the performance period,” says the AMA resource.

It is also important to include how costs will be reconciled if a patient receives elective or emergency care from someone else.

**Performance period phase-in.** The “performance period” includes the starting and end dates between which a physician’s performance is measured. This differs from the “agreement term” that covers the length of the contract.

The agreement should acknowledge that, before the first performance period starts, physicians may need time to tailor administrative systems and clinical protocols to the specifications of the pay-for-performance agreement. Model contract language calls for the first 12-month performance period to begin 60 days after the start of the agreement term.

**Claim submission.** Physicians should watch for “potential nuances” in the contract that obligate them to submit claims differently for their pay-for-performance patients than they do for their fee-for-service patients—even though they are covered by the same payer. If payers request additional modifiers or documentation, they need to give physicians sufficient time—60 days is suggested—to incorporate these processes into their workflows.

“Physicians should be on the lookout for provisions that allow the payer to change the submission and reporting obligations of the physician without due notice, many of which can be ‘effective immediately,’” the AMA resource says. This sentence should be included in the contract: “Payer shall make every effort to minimize the administrative burden associated with Physician’s participation in the Agreement.”


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Data. Physicians must have timely access to data on patients for whose care they are being evaluated. Twenty-four hour access to patient data, quality metrics, itemized billing and patient-encounter information should be available via a secure online portal or dashboard. If this is not feasible, at a minimum weekly updates must be provided.

Ideally, payers should offer infrastructure or technical support to facilitate fulfillment of the physician’s data-transfer obligations. The physician and payer may need to enter into a business associate agreement to ensure proper use and disclosure of patient health information and to be in compliance with Health Insurance Portability and Accountability Act standards.

Quality measures. Measures need to be relevant to the physician’s specialty and based on nationally accepted standards. Any additions, deletions or changes require mutual agreement.

Performance determination. The formula for calculating physician performance must be clearly spelled out in the agreement and payers must not be allowed to unilaterally change the terms. There should be a provision for appropriate risk adjustment. Physicians should be aware that payers often raise quality benchmarks from year to year reflecting the doctor’s increased ability to succeed. They also may lower benchmarks on decreasing costs as those often become more difficult to achieve over time.

Payment and reconciliation. The time frame for payment, reconciliation and any deductions for case management or administrative fees should be clearly defined. There must also be a defined appeals process for physicians to contest the payer’s decisions regarding performance, payment and reconciliation.

Dispute resolution. The agreement may include processes for mediation or arbitration. The resource, however, notes that physicians may not want to make these to be legally binding. Not doing so may give aggrieved physicians more leverage in the dispute.