



Evaluating bundled or episode-based contracts

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Disclaimer

This document is provided for informational purposes only and is not intended as legal advice, or as a substitute for the legal advice of an attorney.

Objectives



Introduction

With the rise in health care expenditures and an emphasis on quality improvement, federal 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. In these new models physicians have the opportunity to maximize the reward by increasing the quality of care while decreasing unnecessary cost. To ensure that you are prepared to successfully and sustainably adopt these new models, this contracting resource will help you understand key contractual terms and conditions commonly used in bundled or episode-based agreements and increase your ability to strategically negotiate with commercial payers.

Bundled or episode-based agreements

Today, the commercial market employs a number of alternative payment models, including pay-for-performance, episode-based and bundled payment, capitation, shared savings and retainer-based practice models. Some health care delivery systems get paid by some of these models, for example, accountable care organizations (ACOs) and medical homes.¹ This module outlines issues physicians should consider when engaging in alternative payment models, focusing on bundled or episode-based arrangements.

Bundled or episode-based model

In a bundled payment methodology a single, bundled payment from the payer to the physician covers services delivered by multiple providers during a single episode of care or over a specific period of time. For example, if a patient has cardiac bypass surgery, rather than making one payment to the hospital, a second payment to the surgeon and a third payment to the anesthesiologist, the payer would combine these payments for the specific episode of care (i.e., cardiac bypass surgery) and make one payment for the total episode, including the facility charges. Many physicians already have experience with bundled payments governing an episode of physician services. Common examples include global surgery periods and global payments for obstetrical care. Increasingly, payers are introducing bundled payment models that include a broader array of services, including services provided by physicians and other providers.²

Contractual issues in bundled or episode-based agreements

Recitals

Recitals present an opportunity to set the stage for the agreement by clearly stating the intent of the parties to improve care quality and lower the cost of care, and may also include definitions of terms used throughout the agreement within

¹ Mark W. Friedberg et al., Effects of Health Care Payment Models On Physician Practice In the United States, Rand Corp. (2015) available at http://www.rand.org/pubs/research_reports/RR869.html (last visited June 5, 2015).

² Bundled Payments, American Medical Association, available at <http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/private-payer-reform/state-based-payment-reform/evaluating-payment-options/bundled-payments.page> (last visited June 5, 2015).

the recitals. However, depending on the jurisdiction in which the agreement is entered, the recitals themselves may not be contractually binding on the parties and, thus, key substantive provisions related to the obligations and duties of the parties should be set forth in the body of the agreement and not the recitals.

Key questions: Recitals

There are substantive provisions related to the obligations and duties of the parties set forth in the recitals rather than the body of the agreement. Does that seem right? No, that could be problematic, depending on what jurisdiction you are in. It is recommended that the agreement be revised so that any substantive provisions are incorporated into the body of the agreement, rather than the recitals, to ensure that they will be binding upon both parties.

Model language: Recitals

Whereas, _____ is a _____ [insert specialty] physician practice (“Physician”) that provides high quality medical care to its patients and seeks to establish programs and protocols to ensure that it delivers the most optimal care to its patients at a low cost.

Whereas, _____ is a health insurer (“Payer”) that provides health insurance benefits to its Members and seeks to establish programs and protocols to ensure that it provides coverage for the most optimal care for its Members at a low cost.

Whereas, Physician and Payer seek, through their mutual agreement forthwith and as described herein, to provide high quality care to those Member patients who may best benefit from the program and protocol as set forth in this Agreement.

Term of agreement

Many bundled or episode-based agreements require a three year term, although some use a five year term. This extended term recognizes that it takes time for patient engagement in healthy behaviors to have an impact on quality outcome measures. Often payers develop models with a specific term in mind based on their resource allocation for the model, and may not be flexible in contract negotiations on alterations to the length of the term. Ultimately the particular length of the term of the agreement may not necessarily be as important as the other contractual provisions governing termination of the agreement and post-termination obligations, which will have a greater impact for the physician because those provisions will dictate whether the physician can exit an agreement if the arrangement is not working well. The term of the agreement, therefore, should be viewed as a guidepost for the physician in terms of what the expectations of the payer are, rather than an absolute start and end-point of the agreement.

Key questions: Term of agreement

What are the benefits and risks of a longer agreement term (e.g., five years vs. three years)? A longer agreement term may allow more ramp-up time for physicians to make changes to their practice to meet the requirements of the model, thereby increasing the likelihood of success. For bundled and episode-based models, longer term agreements may prove difficult in later years because of organizational or commitment changes of other providers, or because of changes in standards of care.

My agreement has an “automatic renewal” clause—what is this? Automatic renewal clauses are common in agreements and not a cause for alarm if structured properly. Automatic renewal clauses can allow successful arrangements to continue without additional negotiations. Often, from a contract administration perspective, neither the payer nor the physician want to spend time and resources re-executing an agreement that is otherwise working for both parties. It is important, though, to make sure that the agreement has adequate termination language to allow the physician to exit the agreement if it is not working.

Model language: Term of agreement

Term. The term of this Agreement shall begin on _____, 20__ (the “Start Date”) of this Agreement and shall expire three years following the Start Date of this Agreement (the “Initial Term”). This Agreement may automatically renew for additional twelve (12) month periods (each a “Renewal Term”) unless either Party gives written notice of intent to terminate not less than ninety (90) days prior to the end of the then-current term, or in the event of termination per the termination clause of this agreement (collectively the Initial Term and each Renewal Term, the “Term”). The provisions of this Agreement shall continue for the Term of this Agreement, notwithstanding changes in the Payer’s design or requirements of this or similar payment arrangement models, and shall only be altered with the signed express written agreement of both Parties, pursuant to Section ___ [amendment section] herein.

Cooperation and collaboration

The payer and the physician should be engaged on an ongoing basis to ensure that the bundled or episode-based agreement is working for both parties. Some payers set this dialogue up formally, and others have *touch point* staff who communicate on a regular basis with the physician. Here physicians should consider whether they want to be contractually bound to participate in formal, recurring meetings or conference calls. At a minimum an expression in the agreement that both parties intend to collaborate and cooperate to ensure the physician’s success in the model can set the right tone for the agreement.

Model language: Collaboration

Collaboration. The Parties to this Agreement will, throughout the Term of the Agreement, work together to ensure the success of the Agreement. The Parties intend to communicate and collaborate to foster the productivity of the Agreement, including, participation in the development and testing of new performance measures. Such communication and collaboration shall entail, at a minimum, monthly conference calls, or other frequency conference calls mutually agreed upon by the Parties, at a time and date to be mutually determined by the Parties, as well as the establishment of a point of contact at both Parties to facilitate real time communication as well as such monthly conference calls.

Patient assignment

A bundled or episode-based agreement should address how patients will be assigned and attributed to those providing health care. This is an important aspect of the agreement because physicians will be compensated or, in a two-sided risk model, penalized based on the care outcome and cost of that specific patient population. In an episode-based model, attribution of charges or designation of the principle account physician should be clear in the agreement language. In either model specific clinical criteria for patient assignment should be spelled out in the agreement. The agreement should clearly specify if the assignment is to an individual physician or a group practice. If a patient receives emergency or elective care from someone else, how those costs are reconciled will be important. Often, physicians and payers spend a significant amount of time negotiating these terms because either party’s risk can increase or decrease based on where the line is drawn for patient assignment.

Key questions: Patient assignment

My agreement gives the payer discretion to decide which patients can be included in the model, and I don’t see any specifics. Should I push back on this? Yes. Specific health factors, including BMI, presence of comorbidities, etc., should be stated clearly in the agreement as baselines for patient assignment. Physician expertise should be strongly influential in this aspect of the contract negotiation; the physician is best suited to calibrate which terms for participation will foster the success of the model overall.

The agreement says that the payer will give me a list of patients who will be considered as part of the incentive program after the end of the first year. Should I ask for this language to be changed? Yes. 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. The agreement should also specify that the payer will provide a system for physicians to access a listing of patients whose health care data is being attributed to the model.

Model language: Patient assignment

Patient Assignment. For purposes of the payment set forth therein, patients will be attributed to a Physician to measure performance on a prospective basis based upon specific clinical criteria mutually agreed upon by the parties in advance of the beginning of the performance year. With the express agreement of both Parties, reconciliation may be performed at the conclusion of the performance year to determine any retrospective adjustments to the patient mix attributed toward the Physician's performance determination. Payer shall provide historical data at least sixty (60) days prior to the first day of each performance period, to allow Physician to understand the patient mix assigned at the beginning of each performance period. Physician shall have the opportunity to object to and appeal, in accordance with the appeal procedures set forth herein, the patient mix assigned for the applicable performance period for a period of thirty (30) days following the commencement of the then applicable performance period.

Covered services

One of the key things that the agreement should contain (or incorporate by reference) is language that clearly and comprehensively describes all of the diagnoses within an episode by ICD-9 and ICD-10 codes and all procedures and items included in the episode by Current Procedural Terminology (CPT®) or HCSPCS codes. Additionally, the agreement should clearly specify what types of claims the physician may submit as his/her own. For example, the agreement should clarify whether covered services include those services provided by both physicians and non-physician practitioners and ancillary personnel, and specify whether those services will be considered incident to, or independent from, the physicians' services.

Key questions: Covered services

My payer includes a chart on its website that lists the procedure codes and diagnoses that are included in the agreement. Is this sufficient? No. Typically if a payer is reluctant to include a listing of the specific procedure codes and diagnoses to be included in the agreement, that is a signal the payer may view it as within their sole discretion to change which procedures and diagnoses are included without the agreement of the participating physician. You should ask to include this information as part of the agreement and can suggest that the chart be included as an appendix to the agreement.

Model language: Covered services

Covered Services. During the Term of this Agreement, Physician shall be eligible to receive bonus payments based on the criteria set forth herein for the services and corresponding Current Procedural Terminology (CPT®) codes set forth on Exhibit ____ attached hereto and by reference incorporated herein for services he or she personally performed and those that were performed "incident to" Physician ("Covered Services"), and which may be amended, from time to time, by mutual, written agreement of both parties, pursuant to Section _____. Those Covered Services set forth in Exhibit ____ which are designated as part of an "episode" of treatment shall not be separately billed by the physician and/or "incident to" provider during the episode period when treating a covered person.

Performance period and phase-in

The agreement should include performance period start and end dates. In some cases multi-year agreements may include several performance periods within the agreement term, usually on an annual basis. Prior to the first performance period, physicians may need an initial ramp-up period to tailor administrative systems and protocols to the requirements under the alternative payment model, and this period should also be specified in the agreement. While performance measure benchmarks are typically not included in this provision of the agreement, these benchmarks may vary in each performance period, so these provisions should be evaluated together (e.g., do you need the initial performance period to begin after a set period of time from the start of the agreement to account for an initial ramp-up period and/or have the performance benchmarks be modified to account for the need for an initial ramp-up period?).

Key questions: Performance period and phase-in

What is the difference between the agreement term and the performance period? The agreement term encompasses the entire time period of the agreement. A performance period, on the other hand, is the time period during the agreement in which the physician's performance is measured. Typically, there are multiple performance periods within an agreement's term (e.g., three performance periods of 12 months each within a three-year contract term).

There is language in my agreement about the beginning and end dates of the performance period. Does this need to be included? Yes. For both pay-for-performance and bundled or episode-based models, physicians can expect that payers will define specific periods of time during which quality improvement or cost reduction will be measured. Typically, payers utilize a year-long performance period, with some variance at the beginning and end of the agreement term, to allow for a ramp-up and/or wind down period.

My agreement appears to have different metrics or goals for each performance period. Does this make sense? Yes. As your practice becomes familiar with the bundled or episode-based model, your achievement on quality and cost metrics may be variable. You should look carefully at these provisions to ensure that you can meet the benchmarks for each performance period, and that the model continues to be desirable for your patients and practice as the performance periods progress.

Model language: Performance period and phase-in

Performance Period. During the Term of this Agreement, Physician's performance shall be measured during each "Performance Period." For purposes of this Agreement, each "Performance Period" shall be a twelve (12) month period. Notwithstanding the foregoing, to allow the Physician and Payer time to develop the appropriate protocols and procedures to ensure the success of the arrangement described by this Agreement, the first Performance Period shall be a partial period and will start sixty (60) days following the Start Date of this Agreement and end twelve (12) months following the Start Date. Thereafter, each Performance Period shall be a full twelve (12) month period.

Spotlight: Defining an episode

For bundled or episode-based payments, the performance period may be defined by when a care episode begins and ends. Here the agreement should specify which diagnoses or procedure codes trigger the commencement of an episode, as well as which services are covered during the episode of care.

Example: Hip fracture episode

Treatment for a hip fracture may appear to be a relatively defined episode of care, with an orthopedic surgeon managing the care of the patient within the hospital setting. Even for this episode, however, it is important to include specific contractual language to specify whether the episode includes follow-up care or surgery, management of complications from surgery, or other health conditions that develop that are not related to the initial episode within a specified time period (e.g., the patient with a hip fracture goes home and develops community-acquired pneumonia within 30 days of the surgery). In general, more detail is better than less when defining the episode in the agreement.

Example: Congestive heart failure episode

Some bundled payments include the services of multiple physicians and providers across several practice settings; precisely defining when the episode begins and ends in the agreement itself is particularly important in this scenario. An episodic, bundled payment for a patient who has experienced chronic heart failure might be limited to the time period of an inpatient admission for a heart attack, or may extend to include the initial inpatient admission, follow-up outpatient care, and cardiac rehab (including the services of multiple physicians and non-physician practitioners within each setting).

Claim submission

A bundled or episode-based agreement should outline payer requirements in regard to administrative procedures for filing claims and data reporting. Payers may include contractual language to obligate the physician to submit claims using different procedures than what is required for other claims going to the same payer. Physicians should pay attention to these potential nuances to ensure they are submitting claims in accordance with the agreement's requirements and payments are received. 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." Physicians should also ask for appropriate notice and implementation time to implement any changes and avoid both administrative and performance issues.

Key questions: Claim submission

The payer has said that it will give me thirty (30) days' notice prior to changing claim submission procedures. Is this typical? The amount of lead time before administrative changes, like claims submission procedures, can vary. Here you should consider how much time it typically takes your practice to implement an administrative or claim workflow change; if you think you need more time you can suggest 60 days as an alternative. Note that from a contractual perspective it's very important this time period correspond with the "Termination without cause" timeframe so that if the proposed modification is unworkable, you can exercise your right to terminate the agreement.

Model language: Claim submission

Claim Submission. Physician shall submit claims for Covered Services in the same manner as Physician submits claims for covered services under Physician's fee-for-service participation with Payer. Upon request and subject to the mutual written consent of both Parties, Payer may require additional modifiers, documentation, and/or processes for the submission of claims to be paid under the Agreement. Payer's request to add such modifiers, documentation, and/or processes for the submission of claims to be paid under the Agreement shall be provided to Physician at least sixty (60) days prior to required implementation of the same, and shall only be implemented with the express written consent of Physician. Payer shall make every effort to minimize the administrative burden associated with Physician's participation in the Agreement. Physician shall make every reasonable effort to accommodate the reasonable requests of Payer to consider new processes for the submission of claims for Covered Services under this Agreement. Under no circumstances shall the Physician's compensation under this Agreement be decreased or otherwise affected by the Parties failure to come to an agreement about additional modifiers, documentation, and/or processes for the submission of claims to be paid under this Agreement.

Data

Accurate performance data is essential to a physician's success in a bundled or episode-based model. There should be clear provisions outlining the obligations for both payers and physicians in regard to data reporting. With respect to the data produced by the payer, physicians should have timely access to data relating to those patients within the model, as well as resources for data management. Physicians should negotiate for contract terms that obtain the best feedback loop available for data that can be readily understood and employed in the practice setting.

Key questions: Data

Some of my colleagues who are participating in bundled or episode-based agreements have data dashboards to help them keep track of how they're performing, but my agreement doesn't include that. Is this a deal-breaker? Not necessarily. A payer is unlikely to create a data dashboard for a single agreement if they do not already have one in place, so there are alternative mechanisms for access to data that you can ask for, such as individual weekly performance reports. While real-time access to an online portal is ideal, the important thing is that there is some system in place to help you manage and understand the data upon which the payer is measuring performance. Ask the payer for a copy of a typical performance report to see if it is something that is workable for you. Keep in mind that raw claims or cost data alone is unlikely to be sufficient for purposes of tracking your performance in the model.

Key questions: Data continued

There are some provisions in my contract about me submitting data, but the format is not specified. Is that typical?

Bundled or episode-based agreements can rely, in part, on physician-submitted data, including patient satisfaction data. The contract should clearly outline what the physician's obligations are and, ideally, the payer should offer some infrastructure or technical support to facilitate this data transfer.

There is a reference in the contract to executing a HIPAA-compliant agreement with the payer and/or another provider. Does this sound right? Depending on the type and intended use and/or disclosure of the data, physicians may be required to execute business associate agreements under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing regulations. These agreements may be necessary with the payer and/or other providers working together in the model to ensure the proper use and disclosure of patient health information. The agreement may also include requirements for the destruction of patient or performance data upon termination of the agreement and/or end of term.

Model language: Data

Data. Payer shall maintain a twenty-four (24) hour accessible, secure online portal and/or dashboard to allow Physician to view and download patient data and metrics with respect to quality achievement, any reports or tables, and itemized billing, patient encounter, and other data used to evaluate Physician's performance under this Agreement. Payer shall make every reasonable effort to update such data on a daily basis, and at a minimum, shall update such data on a weekly basis. Payer shall provide Physician a comprehensive report, which shall include data in a readable, understandable format for Physician (e.g., Payer shall not only provide raw claims data, but shall provide metrics and analyses to enable Physician to understand the import of such data to the model under the agreement) substantially in the form attached hereto as Exhibit ___. Failure to maintain and update the information available via the online portal and/or dashboard shall constitute a material breach of this Agreement and shall be subject, at the discretion of the Physician, to the Termination provisions herein. Physician shall timely submit patient data, the content and process for submission of which to be mutually agreed upon by the Parties in writing, and failure to timely submit such data may delay the determination by Payer of Physician's performance for the period of time for which such data is applicable. Both Physician and Payer shall make every reasonable effort to notify the other party of any deficit or technical interruption of data availability or reporting.

If required by applicable law, the Parties agree to execute a Business Associate Agreement in accordance with the Health Insurance Portability and Accountability Act, as amended, and its implementing regulations (HIPAA) substantially in the form attached hereto as Exhibit ___ and by reference incorporated herein. Provided, further, in the event that a "business associate" relationship is created under HIPAA between Physician and other participating providers in the program, Physician agrees to execute a Business Associate Agreement with such provider. In the event that a Business Associate Agreement already exists between the Parties, the Parties agree to make every reasonable effort to modify, to the satisfaction of both Parties, such agreement to ensure that the data reporting and transparency provisions of this section may be implemented.

Performance determination

Physicians should expect to see a performance determination calculation laid out in the agreement, but should be aware that the calculation may contain a number of variables that are addressed in other contractual provisions (e.g., provisions pertaining to patient assignment, quality measurement, risk adjustment and performance period). Physicians should review the agreement in its entirety to ensure that all of the variables are defined in the agreement somewhere; the contractual language should not be vague or give the payer sole discretion to alter the variables that will be considered in the determination of performance. Importantly, there should be a provision allowing for appropriate risk adjustment to ensure that outliers do not negatively influence performance.

Key questions: Performance determination

My agreement appears to calculate my performance and compensation differently each year. Is this typical or does that seem off? Many payers change the benchmarks for success year-by-year. Often, bundled or episode-based agreements set an initial benchmark for the first year to allow the physician some flexibility to ramp up and succeed, and then raise the benchmark in later performance years to account for the physician's increased capacity to succeed over time.

My agreement requires me to lower costs by eight percent in the first year but, in later years, I am only expected to lower costs by four percent. Is that a drafting error? Probably not. Payers recognize that while physicians may be able to tackle the low-hanging fruit in the early years of the model, lowering costs may prove more difficult in later years. You should review your own data and plans for administrative changes to determine whether you will be able to continue to achieve savings in the later performance years.

There is a provision here that says I can only refer to in-network providers to receive compensation under the model, but I sometimes send my patients to out-of-network colleagues. Should I sign that? Not necessarily. Payers may include penalties in this section of the contract related to referrals to out-of-network providers, or clauses that commit the physician to use in-network providers only. You should omit that language or reconsider your participation if it will not work for your practice. Alternatively, you can include carve-out language that gives you the right to refer, in your sole discretion, to out-of-network providers when medically necessary.

Model language: Performance determination

Performance Determination. For each Performance Year during the Term of this Agreement, Physician's performance will be determined based on the formula and metrics set forth in Exhibit ___ attached hereto, including risk adjustment factors, and by reference incorporated herein. The method by which Physician's performance is determined, including factors governing risk adjustment, shall only be amended upon mutual agreement of the parties by execution of a written amendment to the agreement by the parties pursuant to Section ___ [amendment provision] of the agreement.

Referrals. Physician shall make a good faith effort to refer to participating providers in circumstances where medical necessity requires that a patient must be referred. Physician has sole discretion as to referrals and may make such decisions based solely on Physician's medical judgment, including, but not limited to, cases of emergency, situations where there is no accessible participating provider with the requisite training and skill for treatment, or when Physician determines that a non-participating provider would provide the optimal patient care for any reason.

Payment and reconciliation

The terms of payment and reconciliation under the bundled or episode-based agreement, including remittance timeframes and processes for appeal, should be clearly defined in the agreement. As with most contract terms, it is important here that the payer does not retain the ability to unilaterally change the payment and reconciliation terms without the signed written consent of both parties.

Key questions: Payment and reconciliation

What payment and reconciliation language should I expect to see in the agreement? The agreement should clearly specify the timeframe for payment, reconciliation, and any deductions for case management or administrative fees. Here physicians should consider whether they prefer a short timeframe for payment and reconciliation (which may be less accurate, but positively affect cash flow), or a long timeframe for payment and reconciliation (which may be more accurate, but negatively affect cash flow). Certain timeframes should also be specified, namely, the timeframe by which the reconciliation process will be completed and payment remitted (e.g., within 30 days from the end of each performance year).

Key questions: Payment and reconciliation continued

What can I do to protect myself in the event that I don't agree with the payment the payer says they owe me? The agreement should specify appeals procedures for physicians to contest the payer's decisions in regard to performance, payment and reconciliation. If a claim is appealed and ultimately some or all of the claim is paid, interest should be deemed to have accrued from the date of submission on the portion of the claim that was paid. At a minimum the agreement should refer to the appeals procedures in place for physicians participating in the plan's fee-for-service contracts. This is also a consideration when thinking about the window for payment and reconciliation.

I am participating in a shared savings program. Is there anything more that I should expect to see in the agreement related to distribution of the savings? The agreement should include specifics about the distribution of savings. For example, the language should be clear about how savings will be divided and whether some savings will be set aside for program administration or infrastructure reinvestment.

Model language: Payment and reconciliation

Payment and Reconciliation. Payer will remit payment pursuant to the performance determination and perform any necessary reconciliation within thirty (30) days of the end of each performance period. Physician may appeal the performance determination and payment within thirty (30) days of receipt of payment. Payer must respond to such appeal within fifteen (15) days of receipt. Appeals that cannot be resolved within thirty (30) days of the date of Physician appeal shall be resolved pursuant to the dispute resolution process set forth in Section ___ [dispute resolution section] of this Agreement. At the conclusion of the appeal, interest on the portion of the claim or the claim paid shall be calculated based on the date of submission of the claim and paid to the Physician.

Quality measures

Bundled or episode-based agreements often skate over the specifics of measure development and the calculation and determination of measure performance, but these terms should be outlined clearly in the agreement. First, the measures to be used should be defined to ensure they are relevant to the specialty of the physician; measures that are developed with physician input are optimal, particularly same-specialty physician input. Some payers use standard measure sets such as the Healthcare Effectiveness Data and Information Set (HEDIS), while others develop their own measures.

Key questions: Quality measures

My agreement says that the payer will base my performance on measures developed by the payer. Is this common?

Some payers use their own measures, but base them on nationally accepted measure sets. For example, Blue Cross Blue Shield of Massachusetts has its own measures for its Alternative Quality Contract program, but bases them on well-known, national measures. The important thing here is that you have some familiarity with the measures and they are subject to change only upon your express written agreement.

Is it to my advantage to have the measures variable year-by-year? The payer says that, if the agreement is drafted to allow that flexibility, they can get rid of measures that are not working. It can be to your benefit to have some changes to the measures each year. As you and the payer learn what works and what doesn't work for your practice, you may want to switch out the measures on which you will be judged. However, it should also be clear in the agreement that measures cannot be added, deleted or significantly altered without the signed written agreement of both parties.

My payer has a committee that reviews and develops metrics for quality and performance measurement. Should I try to be involved in that committee, and is it possible to get that included in the contract? Maybe. You should ascertain the degree to which physicians participate in the payers' decisions on which measure sets to use and renew (e.g., does the payer have a physician on the committee, or do they follow national specialty medical society recommendations). The volume of physicians who participate in most bundled or episode-based contracts likely makes it impossible to be actively involved in this way with payers, unlike similar health system or network quality committees. It is important, however, to ensure that physician input is provided whether it be from you or other physicians.

Key questions: Quality measures continued

The quality measures are listed in the appendix of my agreement. Is this sufficient? Yes, if the agreement provides that the appendix, exhibits or any attachments to the agreement are incorporated fully into the agreement. There should also be contractual language incorporating the appendices by reference; the document's mere inclusion at the end of the agreement does not necessarily mean it has been incorporated as part of the contract and, thus, anything contained therein may not necessarily be contractually binding on the parties. The agreement—whether in the appendix or exhibit—should clearly state the measure sets or other source from which the measures will be drawn, as well as state that the measures cannot be changed without your signed written agreement.

Model language: Quality measures

Quality Metrics. The pay-for-performance incentive payments shall be based upon the quality metrics set forth in Exhibit ___ attached hereto and by reference incorporated herein. The quality metrics may be amended only by mutual agreement of the parties by execution of a written amendment to the agreement by the parties pursuant to Section ___ [amendment provision] of the agreement. The quality metrics applicable to the Physician shall be relevant to the Physician's specialty, as applicable, and shall be based upon nationally accepted measure sets (e.g., HEDIS) related to clinical outcomes and developed clinical performance measures.

Unforeseen events

Uncontrollable, game-changing events, such as the introduction of a high-cost specialty drug or a national drug shortage, can adversely affect the financial benefit of participation in a bundled or episode-based model. Absent any language to protect the physician, in this situation the payer may take the position that these types of events are included in the financial and business risks taken on by the physician. It is therefore helpful to have some contractual language to shield the physician from such events.

Key questions: Unforeseen events

The payer I am working with does not want to include language on unforeseen events in our agreement. What else can I do to mitigate this risk? Some large providers and networks obtain independent actuarial advice or financial analysis to help understand risk upfront, but the costs for these services can be high. Talk with the payer and your same-specialty colleagues about the incidence of unforeseen events in prior performance years. And make sure your language in regard to contract termination is strong; if an unforeseen event does happen, you can use the termination provisions as leverage to negotiate with the payer or terminate the agreement and exit the program.

My colleague recommends that we obtain stop-loss insurance. Is this necessary? Maybe, depending on the level of risk you will assume by participating in the alternative payment model. The AMA has educational materials on stop-loss insurance that are a good resource. You can ask the payer about what stop-loss insurance they offer, or ask them to build a stop-loss provision into the agreement itself.

Model language: Unforeseen events

Immediate Termination Due to Unforeseen Events. In the event that, due to events outside of Physician's control, including, for example, the dramatic increase in the cost of a prescribed medication as part of the treatment plan of a patient, the cost of an episode of care substantially exceeds the calculated episode payment set forth on Exhibit ___ attached hereto and by reference incorporated herein, Physician shall have the right to immediately terminate this Agreement. For purposes of this agreement "substantially exceeds" shall mean an increase of 100% or more of the stated episode payment.

Dispute resolution

Many physicians have some familiarity with standard dispute resolutions, as they are typically included in payer contracts. For bundled or episode-based agreements, payers may be more willing to include language to ensure that the parties have mechanisms in place to quickly, efficiently, and amicably resolve differences and unforeseen issues. These processes

may include informal dispute resolution, mediation and/or arbitration. In the event of a dispute both parties stand to save time and resources by resolving such dispute through these alternatives to litigation. Outlined below in simple language is a timeline and procedures for the dispute resolution process which may need to be tailored to the parties' specific needs, including whether the individual physicians or group practice or network are parties to the agreement.

Key questions: Dispute resolution

I don't see any language in the agreement that says the mediation and arbitration provisions are binding. Should I push to get that language included? No. Often the aggrieved party may need the leverage of litigation to get to a resolution of a dispute. In contractual disagreements between physicians and payers, the aggrieved party is often the physician, and the absence of language stating that these provisions are binding may give some wiggle room for this leverage. This isn't the place, therefore, to argue for hardnosed language.

My colleague said that our state law has some requirements around dispute resolution. Does this sound right, and do I still need these provisions? Some state laws require that the parties demonstrate their agreement by initialing the dispute resolution provisions section specifically, but state law is generally not a substitute for contractual provisions governing dispute resolution. These provisions should absolutely be included, and state law should also be checked to make sure their requirements are properly executed.

Model language: Dispute resolution

In the event of any dispute between the Parties under this Agreement, the Parties shall first negotiate the matter between themselves in good faith. If direct negotiations do not resolve the matter, either Party may demand, in writing, that the matter be submitted to mediation. After delivery of the notice of mediation, the Parties may select a mediator who will render a recommended resolution to the dispute. If the Parties cannot agree upon a mediator, the Parties shall each select a mediator and the two mediators selected by the Parties will select a third mediator. The Parties will share the expense of the mediator, if one mediator is selected and, if three mediators are selected, shall each pay the cost of the mediator they selected and will share equally the cost of the third mediator. If mediation does not resolve the dispute within ninety (90) days after the written notice of mediation is delivered or the Parties are unable to resolve the dispute through negotiation or mediation, either Party may require by written notice that the matter be submitted to arbitration, under the American Health Lawyers Association/American Arbitration Association. Arbitration will be by a single arbitrator acceptable to both parties, who is knowledgeable in health care matters. If the Parties cannot agree upon an arbitrator, the Parties shall each select an arbitrator and the two arbitrators selected by the Parties will select a third arbitrator. The Parties will share the expense of the arbitrator, if one arbitrator is selected and, if three arbitrators are selected, shall each pay the cost of the arbitrator they selected and will share equally the cost of the third arbitrator. The arbitrator's decision shall be binding, and either party may petition a court of appropriate jurisdiction for the award of the arbitrator to be enforced by the court. The arbitrator may award attorney's fees and costs to the prevailing Party, but neither Party shall be allowed punitive damages.

In the event any attorney is employed by any Party to this Agreement with regard to any legal action, arbitration, or other proceeding brought by any Party to this Agreement for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with any of the provisions of this Agreement, then the prevailing Party, whether at arbitration, trial or upon appeal, and in addition to any other relief to which the prevailing Party may be granted, at the judge's or arbitrator's discretion, may be entitled to recover from the losing Party all costs, expenses, and a reasonable sum for attorney fees incurred by the prevailing Party in bringing or defending such action, arbitration, or proceeding, and in enforcing any judgment granted therein, all of which costs, expenses, and attorneys' fees shall be deemed to have accrued upon the commencement of such action and shall be paid whether or not such action is prosecuted to judgment.

At the arbitrator's or judge's discretion, any judgment or order entered in such matter may contain a specific provision providing for the recovery by the prevailing Party of attorney fees, costs, and expenses incurred in enforcing such judgment. For purposes of this Section, attorneys' fees shall include, without limitation, fees incurred in the following: post judgment motions; contempt proceedings; garnishment, levy and debtor and third-party examinations; discovery and bankruptcy litigation.

_____ Physician's Initials

_____ Payer's Initials

Termination

The agreement should clearly state under what circumstances and how the parties may terminate the agreement. There will likely be provisions detailing processes for fixing material breaches of the contract, including timeframes for resolution. Post-termination duties should be specified for both parties, including obligations for the payer to pay any outstanding compensation to the physician or true-up based on a pro rata portion of the performance year.

Key questions: Termination

What is the difference between terminating an agreement “with cause” and “without cause”? Termination of the agreement “without cause” means that you can terminate the agreement if it is not working for you, with a certain notice period for the other party. This is different from terminating a contract “with cause,” where there is some specific deficiency or “material breach” on the part of the other party that leads you to terminate the agreement.

My agreement appears to let me terminate the agreement whenever I decide to do so. This seems positive to me, but is there anything else I should consider here? Typically, provisions that allow termination without cause cut both ways, meaning that if you can terminate the agreement quickly and without a good reason, it is likely the payer has or expects the same latitude. It is important to consider what resource investments you will be making to participate in the bundled or episode-based model, and how much risk you are willing to take on if the payer decides to terminate your agreement—or the model altogether—mid-agreement.

I have a group practice. Do individual physicians in the practice need to terminate their participation if they leave the practice? Probably not. For bundled or episode-based agreements structured on the group level, it is likely that the agreement is between the group entity and the payer, not the individual physician. You should, however, notify the payer if one of the participating physicians leaves the practice, as that information will be important to maintaining accurate performance data.

Model language: Termination

Termination of Agreement. Notwithstanding any other provisions of this Agreement, this Agreement may be terminated as follows:

Termination Without Cause. Except as otherwise provided herein, either Party may terminate this Agreement by giving not less than sixty (60) days’ advance written notice to the other Party. Both Parties shall have the right to terminate the Agreement for cause during any without cause notice period.

Termination For Cause. Payer may terminate this Agreement for “cause” upon thirty (30) days’ written notice at any time except if the Physician materially defaults in performance hereunder, including the failure of the Physician to meet the ongoing Payer qualification criteria and comply with the Payer standards, and such Physician has failed to cure such default during such thirty (30) day period. Any Physician may terminate its participation in this Agreement for cause upon thirty (30) days’ written notice at any time if Payer materially defaults in performance hereunder and Payer has failed to cure such default during such thirty (30) day period.

Termination Upon Mutual Agreement. This Agreement may be terminated at any time by mutual, written agreement of the Parties effective as of the date mutually agreed by the Parties.

Effect of Termination. Upon termination of this Agreement, as herein above provided, no terminating Party shall have any further obligation hereunder except for (i) obligations accruing prior to the date of termination, including reconciliation and payment of any monies due to the Physician from the Payer, and (ii) obligations, promises, or covenants contained herein which are expressly made to extend beyond the term of this Agreement including, without limitation, any indemnities and access to books and records.

Appendix: Contractual provision checklist



Recitals

- Do the recitals clearly define the intent of the parties in entering the alternative payment model relationship?
- Are there substantive provisions in the recitals that should be in the body of the agreement to ensure that they are binding obligations on the parties?



Term of agreement

- What is the length of the term of the agreement?
- Is this period of time sufficient for you to achieve the goals of the program or too long of a time commitment (especially if there is no termination without cause provision)?
- Is there an automatic renewal clause in the agreement? If so, do you have a right to exit the agreement if the arrangement is not working for you?



Cooperation and collaboration

- What contractual obligations, if any, are imposed on both parties to work collaboratively (e.g., monthly meetings) for the success of the program?
- Are they obligations to which you are willing to be contractually bound (i.e., you could be in breach of the agreement for failure to meet the obligations)?



Patient assignment

- Does the agreement specify the process by which patients will be assigned and attributed to a physician in advance of each performance period?
- Does the agreement provide you with rights to object to or appeal the assignment of patients for the applicable performance period?



Covered services

- Does the agreement specify the services by CPT® codes included in an episode of care?
- Does the agreement specify that the covered services cannot be unilaterally modified by the payer?
- Does the agreement specify what types of providers may submit claims for the covered services (e.g., physicians, nurse practitioners, physician assistants)?



Performance period and phase-in

- Does the agreement specify when a performance period begins and ends?
- Do you need the initial performance period to begin after a set period of time from the commencement of the agreement, and/or the performance benchmarks modified to account for an initial ramp-up period, to ensure that the requisite administrative systems and protocols are in place for success?
- With respect to episode-based payment programs, does the agreement clearly define, by diagnoses or procedure codes, when an episode begins and ends?



Claim submission

- Is the process for claim submission clearly set forth in the agreement?
- Does the agreement allow the payer to change your submission obligations without due notice to you?
- Do you have the ability to object and/or terminate the agreement if changes are made to the claims submission obligations imposed on you?



Data

- Does the agreement provide a process by which you will be able to obtain meaningful, timely performance data?
- Does the agreement provide adequate infrastructure for you to submit requested data to the payer?

**Performance determination**

- Are the terms of payment and reconciliation, including the time period for reconciliation, clearly set forth in the agreement?
- Are the performance metrics and calculation included by reference in the agreement, subject to change only upon your signed written agreement, and subject to appeal?

**Payment and reconciliation**

- Does the agreement clearly specify the timeframe for payment, reconciliation, and any deductions for case management or administrative fees?
- Does the agreement provide you with appeal rights to contest a payer's decision with regard to performance, payment, and reconciliation?
- Do you need to amend any existing physician employment agreements or compensation policies with your group's physicians to specify the method by which savings and/or incentive payments earned will be distributed?

**Quality measures**

- What metrics are being measured and do you have the opportunity to provide input on them?
- Are the metrics clearly set forth in the agreement? If they are contained in an exhibit or appendix to the agreement, does the agreement state that such exhibits, appendices, and attachments are fully incorporated into the agreement?
- Are the measures relevant to your particular specialty and/or practice?
- Does the agreement allow the payer to change the measures without your agreement?

**Unforeseen events**

- Does the agreement include provisions to mitigate the risk of unforeseen events such as a substantial increase in the cost of a drug or services provided as part of an episode of care?

**Dispute resolution**

- Does the agreement include dispute resolution provisions (e.g., mediation and arbitration) so that the parties can avoid costly litigation and resolve disputes?

**Termination**

- Does the agreement include a right for you to terminate the agreement without cause?
- Does the agreement address the parties' right to terminate the agreement for material breach? And, if so, does the breaching party have an opportunity to cure the breach within a specified period of time—e.g., within thirty (30) days?
- Does the agreement include provisions that ensure that any incentive payments earned, but not yet paid as of the termination date, are paid to you?